Variants of Hypertrophic Cardiomyopathy?

Steven J. Lester MD, FRCP(C), FACC, FASE

MAYO CLINIC

DISCLOSURE

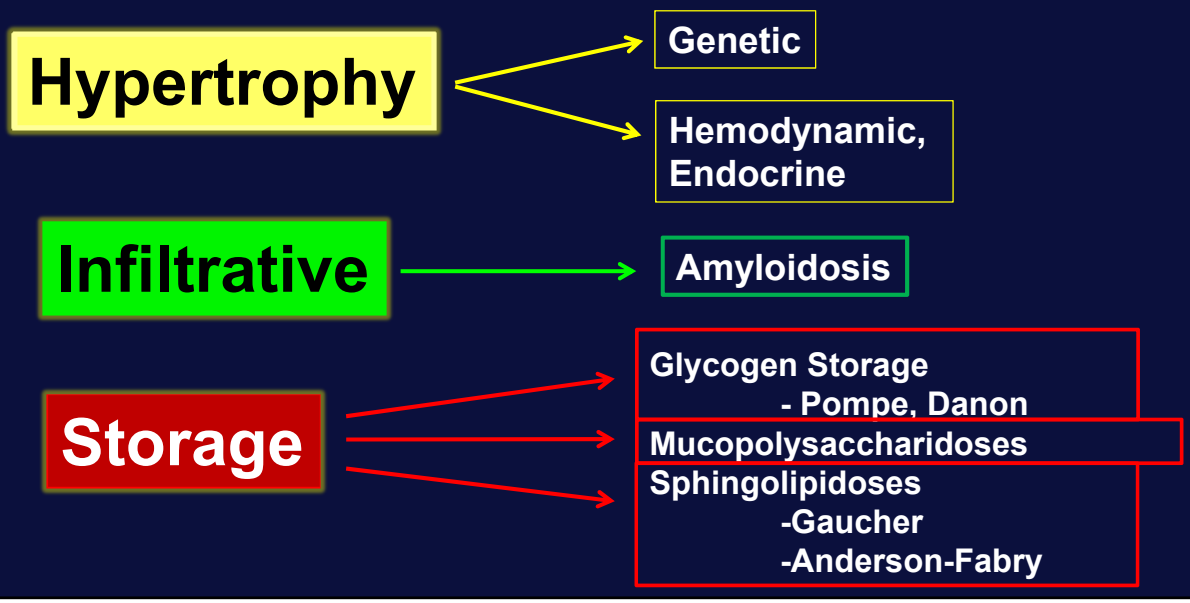
Relevant Financial Relationship(s)

None

Off Label Usage

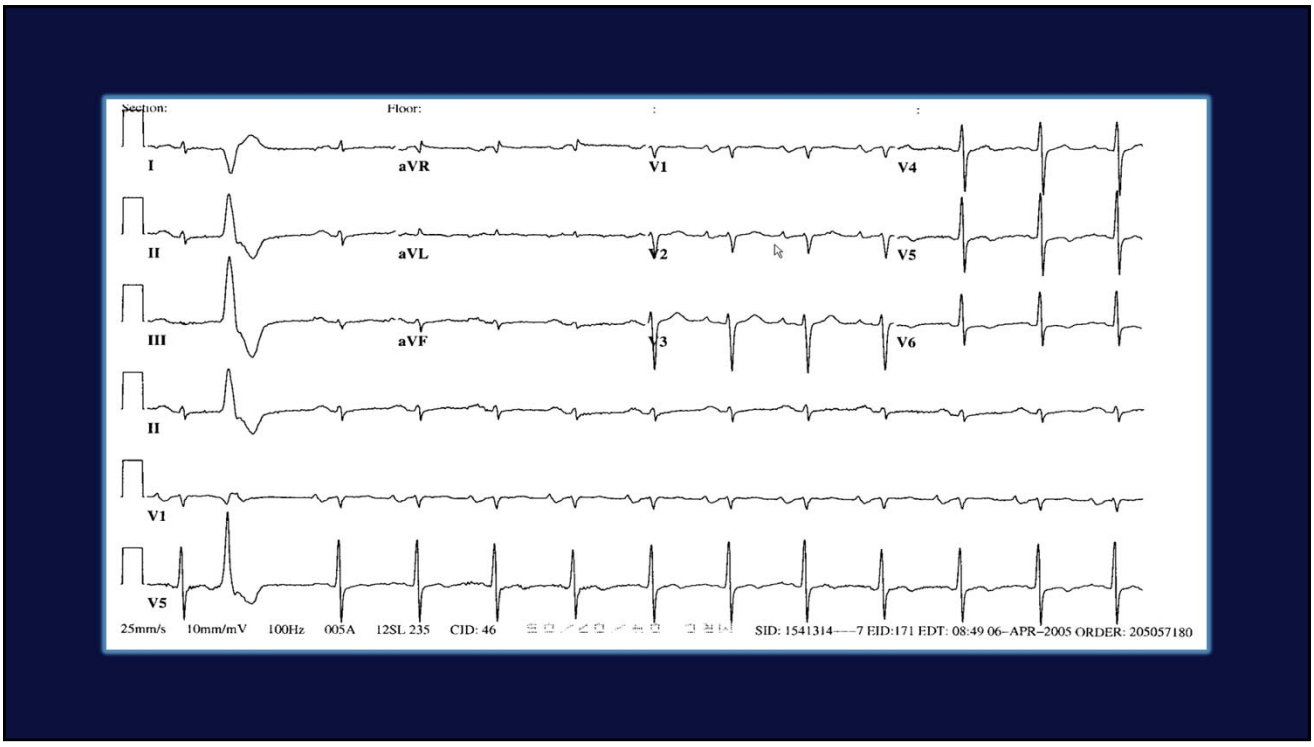
None

Thick Walls Why?



Case

- 47 year old male
- 2005 several near syncope episodes.
- Eventually while at a the Phoenix Suns game had a true syncopal episode.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Floor:
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
V1
V5
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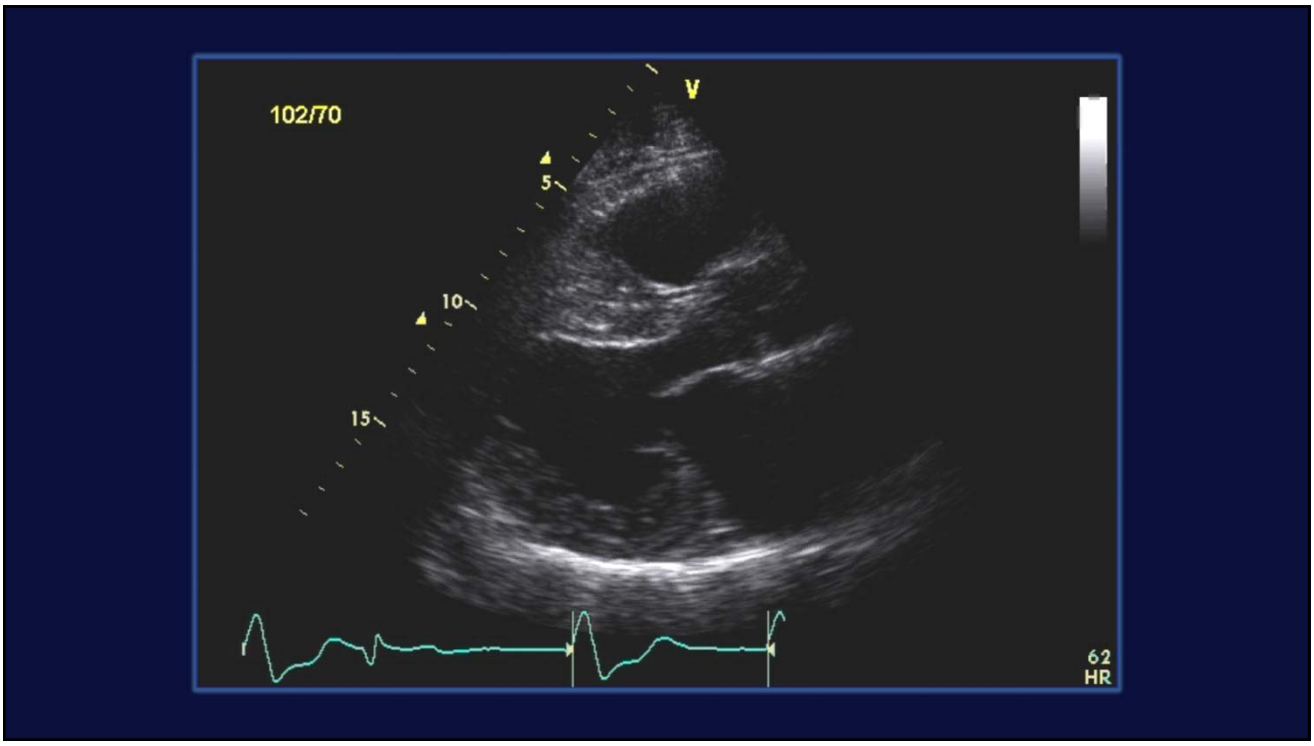
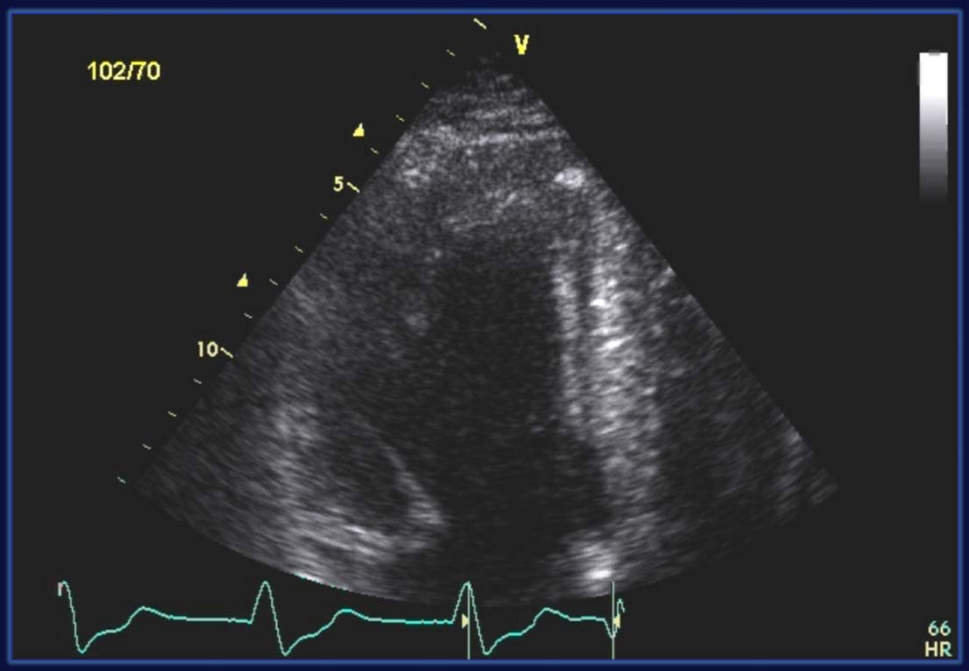
SID: 1541314----7 EID:171 EDT: 08:49 06-APR-2005 ORDER: 205057180


102/70
V
5
10
15
62
HR



Hypertrophic Cardiomyopathy

Echocardiographic Diagnosis

Left Ventricular Hypertrophy ≥ 15mm

The clinical diagnosis of HCM in first-degree relatives of patients with unequivocal disease is based on presence of unexplained increase in LV wall thickness ≥ 13 mm in one or more LV segments.

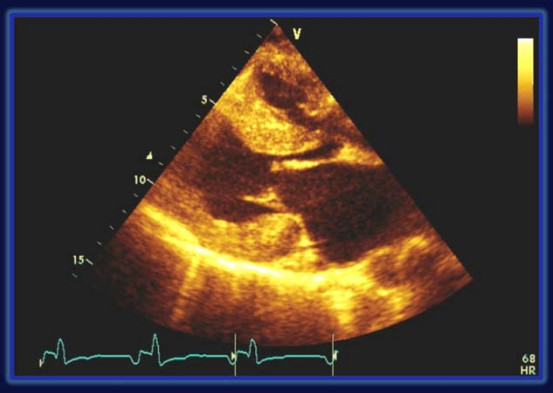
Maron et al. J Am Coll Cardiol 2003;42: 1687

Hypertrophic Cardiomyopathy
Echocardiographic Diagnosis

What is NOT needed for the diagnosis

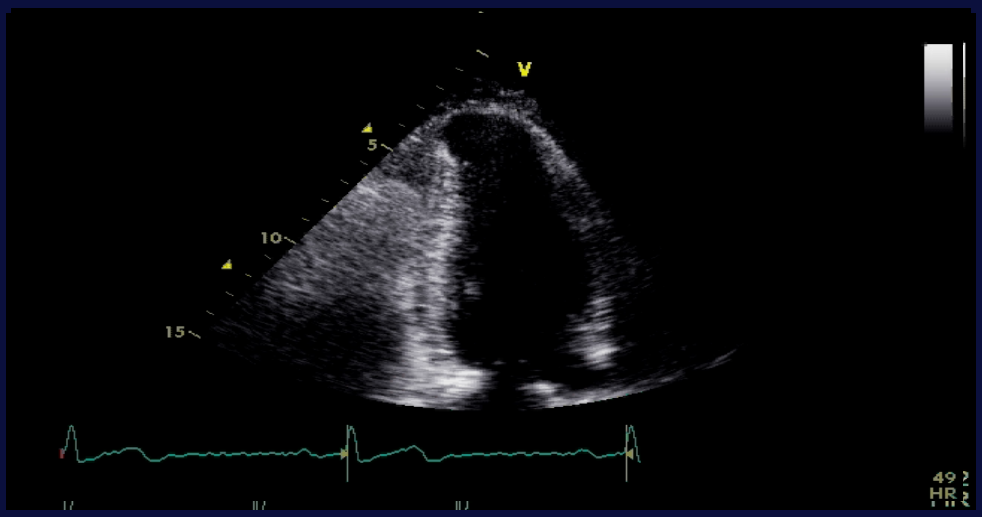
- Asymmetric Septal Hypertrophy (ASH)
- Systolic Anterior Motion (SAM)
- Resting or labile LVOT obstruction

Hypertrophic Cardiomyopathy
Echocardiographic Evaluation

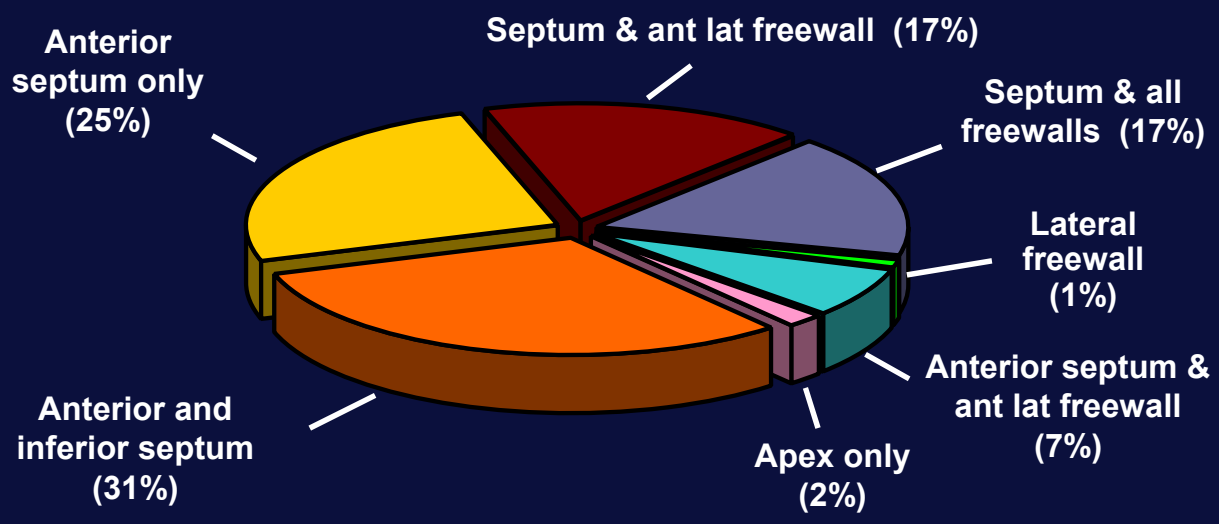


- Extent and distribution of ventricular hypertrophy
- Presence, location & magnitude of outflow gradient.
- Mitral Valve
  - Leaflet length & motion
  - Abnormalities of the papillary muscles & chordal attachments
  - Presence, mechanism and severity of regurgitation
- LV volumes, EF, Strain
- LAVI

Hypertrophic Cardiomyopathy
Diversity in Phenotype

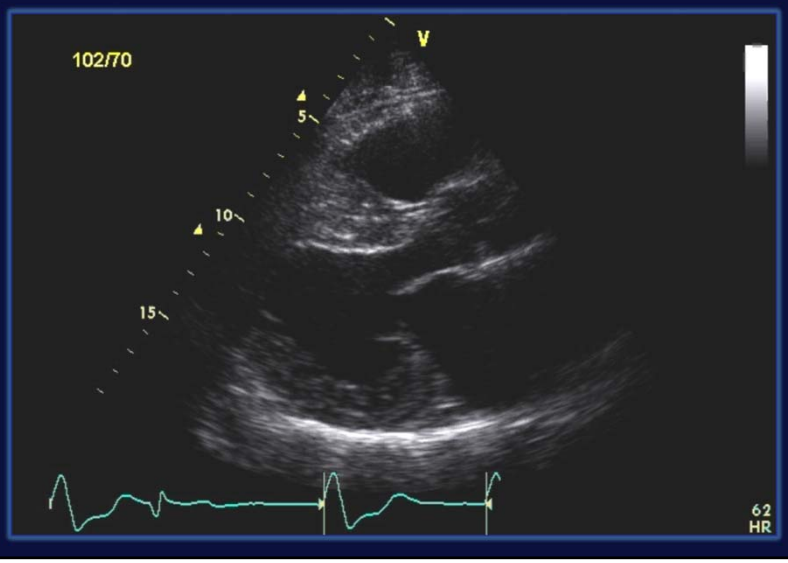


Hypertrophic Cardiomyopathy
Distribution of LVH (600 Patients)

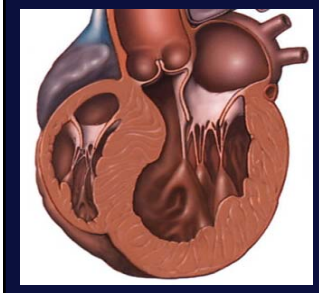
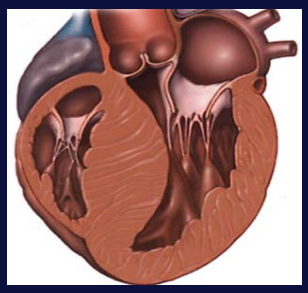
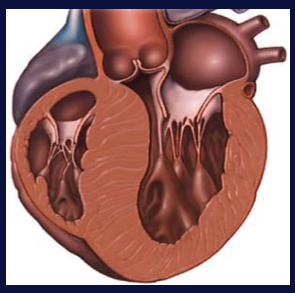


Klues HG, JACC 1995; 26: 1699

Diagnosis:
Hypertrophic Cardiomyopathy



Left Ventricular Morphology in HCM
"Morphogenetics"

Sigmoid Septum	Reverse Septum	Neutral Septum	Apical Variant
			
181(47%) Gene + (8%)	132(35%) Gene + (79%)	32(8%) Gene + (41%)	37(10%) Gene + (32%)

Binder J, et al. Mayo Clin Proc 2006; 81: 459.

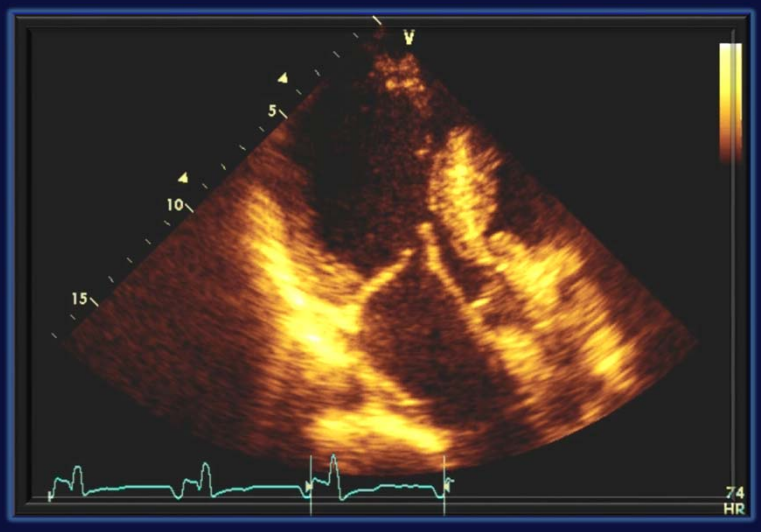
Genetic testing for HCM

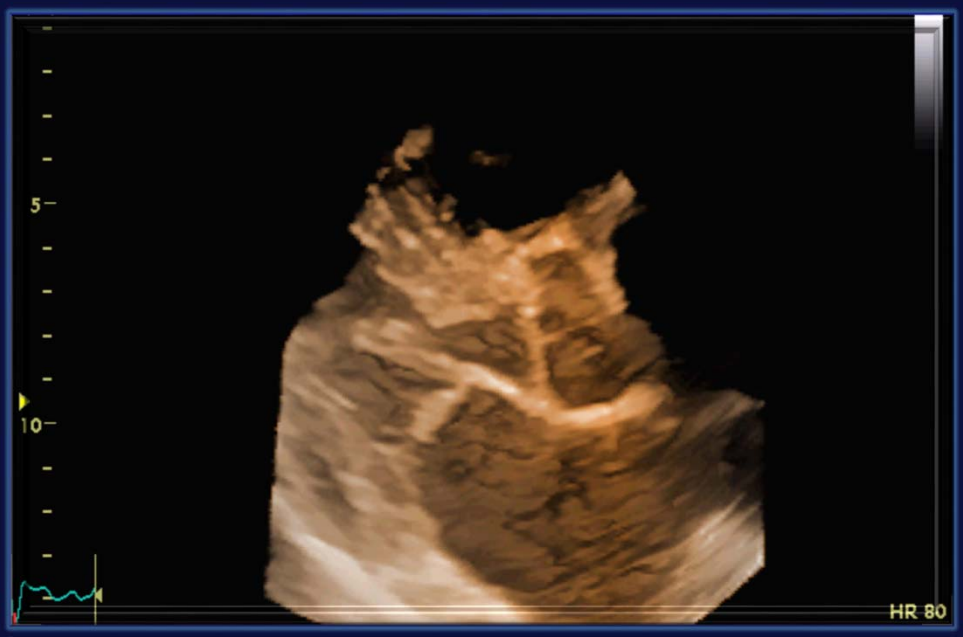
Mayo Clinic Database (389 Patients)

- Echocardiographic anatomic phenotypes are not specific for individual gene mutations
- Specific gene mutations not predictive of prognosis or need for myectomy

Van Driest SL, et al. Mayo Clin Proc 2005; 80: 739

Mitral Valve and Papillary Muscle Anatomy





The Mitral Valve in Obstructive Hypertrophic Cardiomyopathy

A Test in Context

Mark V. Sherrid, MD,[a] Sandhya Balaram, MD,[b] Bette Kim, MD,[c] Leon Axel, MD, PhD,[d] Daniel G. Swistel, MD[e]

ABSTRACT

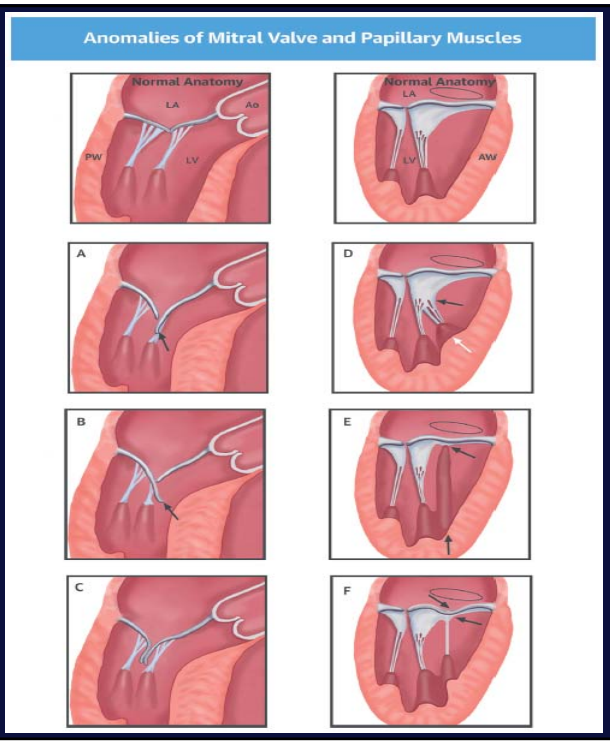
...rophic cardiomyopathy ...though systolic ...uction in the M-mode ...ted as contributing to ...t all levels. They occur in the leaflets, usually elongating them, and also in the submitral apparatus, with a wide array of malformations of the papillary muscles and chordae, that can be detected by transthoracic and transesophageal echocardiography and by cardiac magnetic resonance. Because they participate fundamentally in the predisposition to SAM, they have increasingly been repaired surgically. This review critically assesses imaging and measurement of mitral abnormalities and discusses their surgical relief. (J Am Coll Cardiol 2016;67:1846-58)

The Mitral Valve in Obstructive Hypertrophic Cardiomyopathy

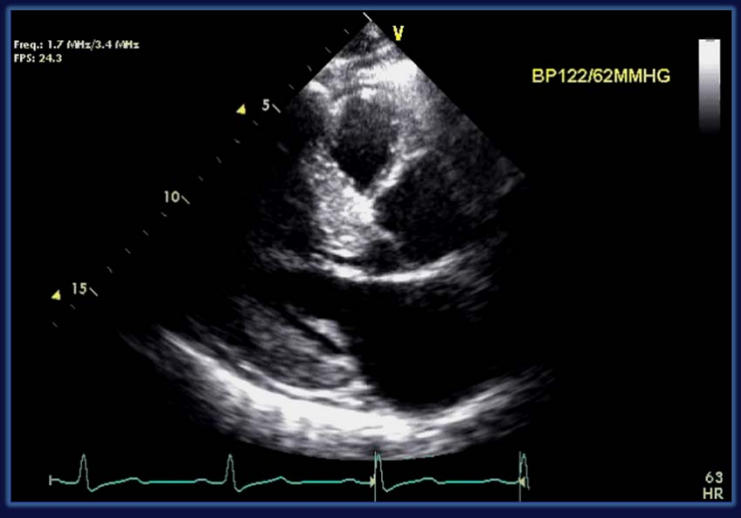
J Am Coll Cardiol 2016;67:1846-58

Left ventricular outflow tract (LVOT) obstruction due to systolic anterior motion (SAM) of the mitral valve is a frequent cause of disabling symptoms in hypertrophic cardiomyopathy (HCM). First-line therapy is pharmacological, with beta-blockade, disopyramide, verapamil, or their combinations (1). However, in patients with systolic gradients ≥50 mm Hg who fail to reach relief of symptoms with pharmacotherapy or who have side effects, surgical myectomy is recommended by international guidelines as the primary and preferred modality for relief of obstruction. An appreciation of mitral abnormalities in HCM has accumulated over the past 20 years (2-13). There has been a natural response by surgeons to this greater understanding of the contribution of mitral pathology to SAM. At myectomy, they have tried to avoid leaving unrepaired pathology by repairing the mitral valve (7-10,12-19). Diagnostic echocardiog... (CMR) discovery of mitral abnormalities in an elderly patient may directly lead to a judgment for surgical septal myectomy rather than alcohol septal ablation (ASA), because ablation only addresses the septal thickening. Patients with mitral valve abnormalities may be left with persistent SAM, gradients, and mitral regurgitation (MR) after ASA (20).

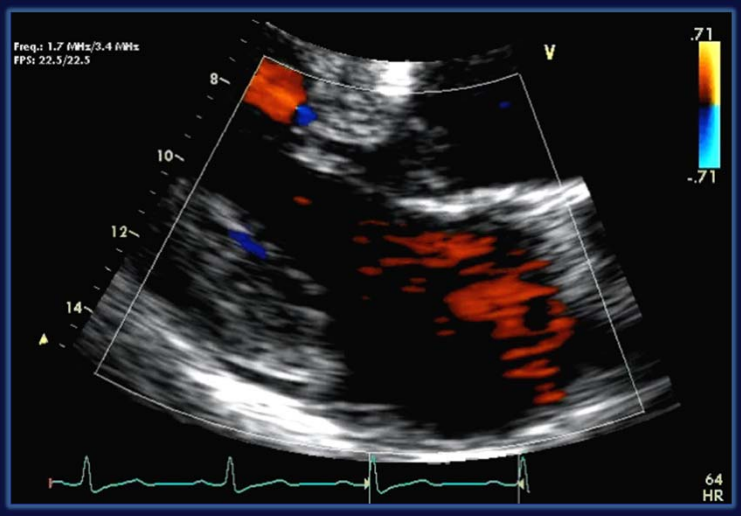
Guidelines support decisions to select surgery for patients with mitral structural abnormalities. The 2011 American guidelines state: "Additionally, specific abnormalities of the mitral valve and its support apparatus can contribute significantly to the generation of outflow tract obstruction, suggesting the potential value of additional surgical approaches (e.g., plication, valvuloplasty, and papillary muscle relocation) and making myectomy more appropriate than alcohol septal ablation in some patients" (21). The



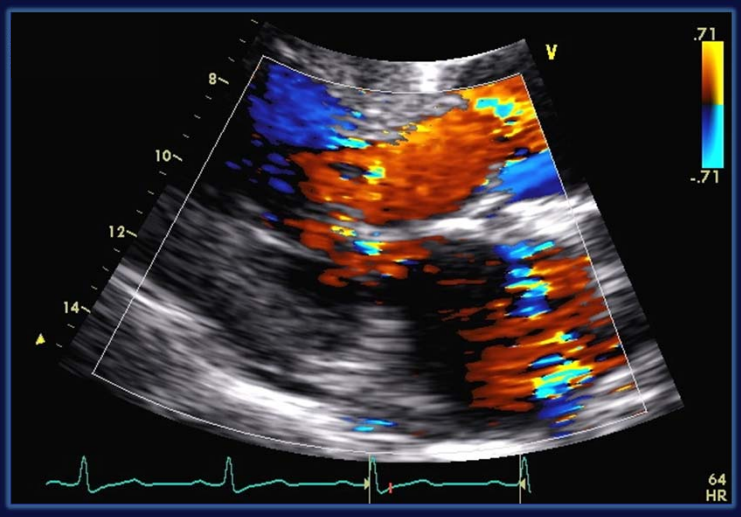
Systolic Anterior Motion (SAM)



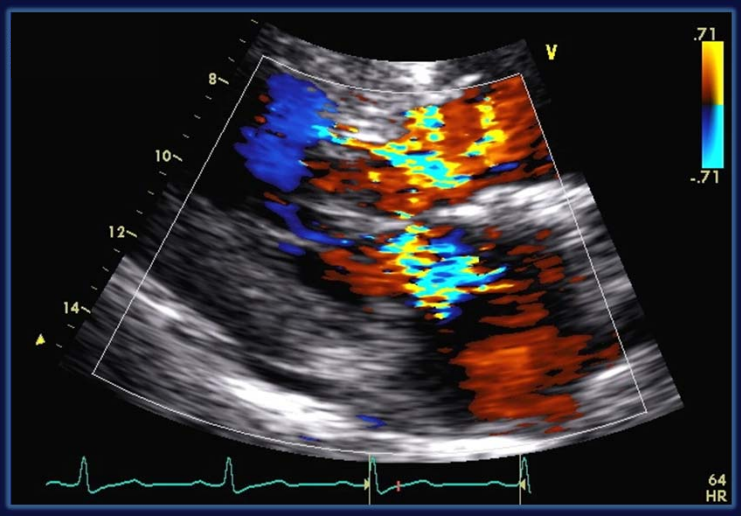
Systolic Anterior Motion (SAM):
LV Ejection ➡ Obstruction ➡ Regurgitation



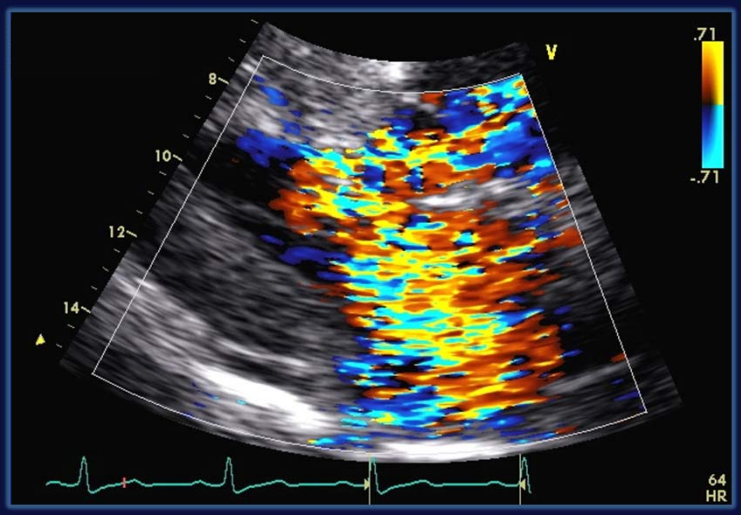
Systolic Anterior Motion (SAM):
LV Ejection



Systolic Anterior Motion (SAM):
LV Ejection ➡ Obstruction

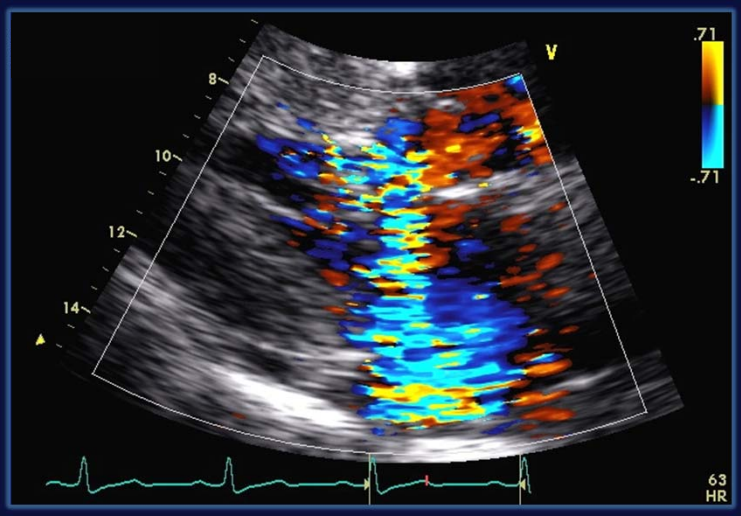


Systolic Anterior Motion (SAM):
LV Ejection ➡ Obstruction ➡ Regurgitation



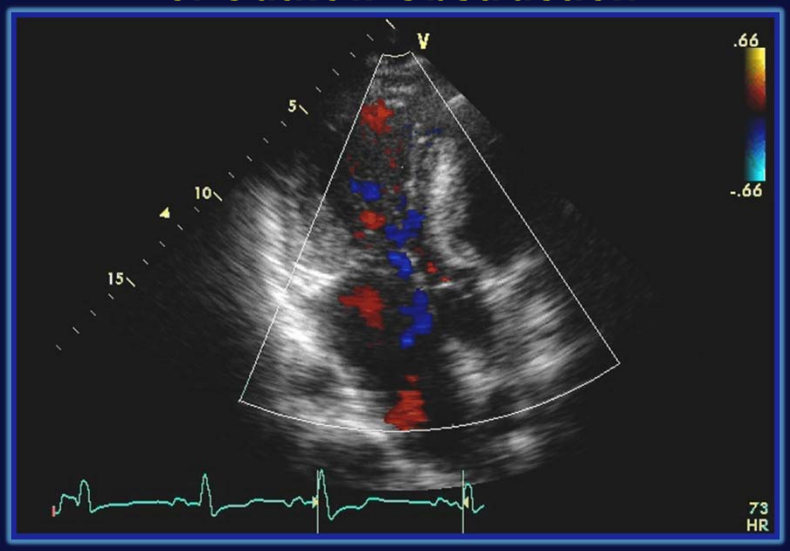
Systolic Anterior Motion (SAM):

LV Ejection ➡ Obstruction ➡ Regurgitation

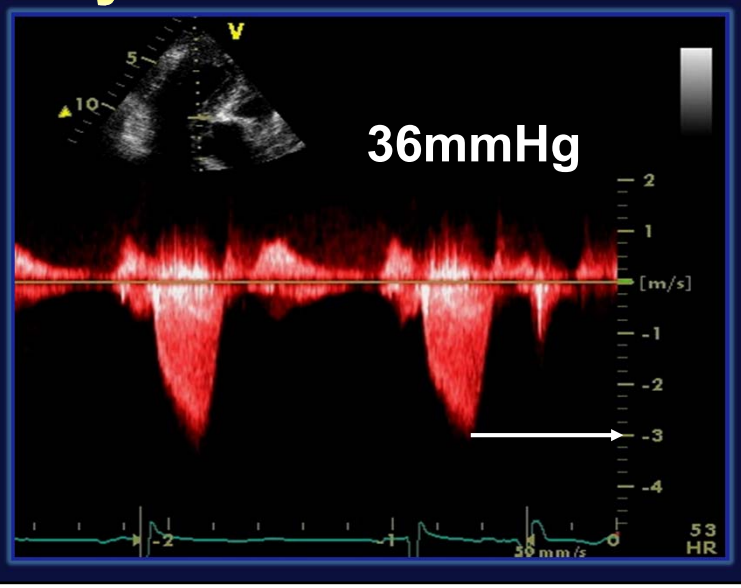


Mitral Regurgitation

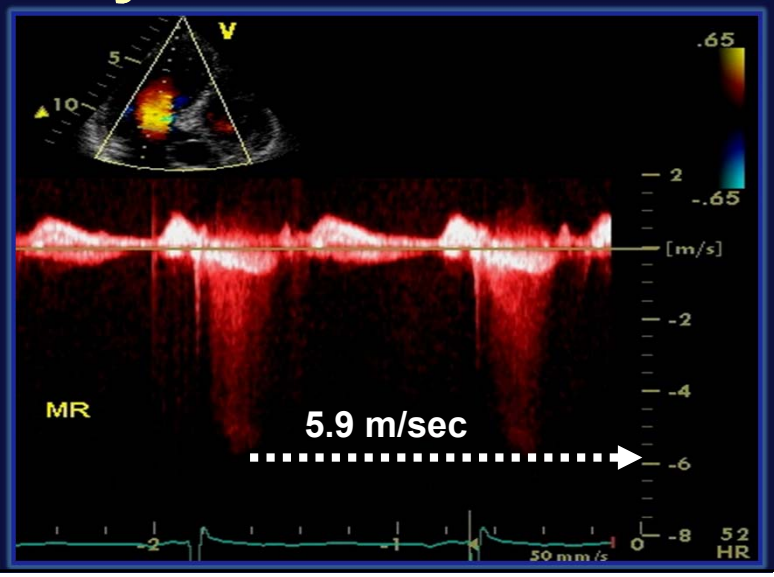
Location, Presence and Severity of Outflow Obstruction



Identify of Location, Presence and Severity of Outflow Obstruction



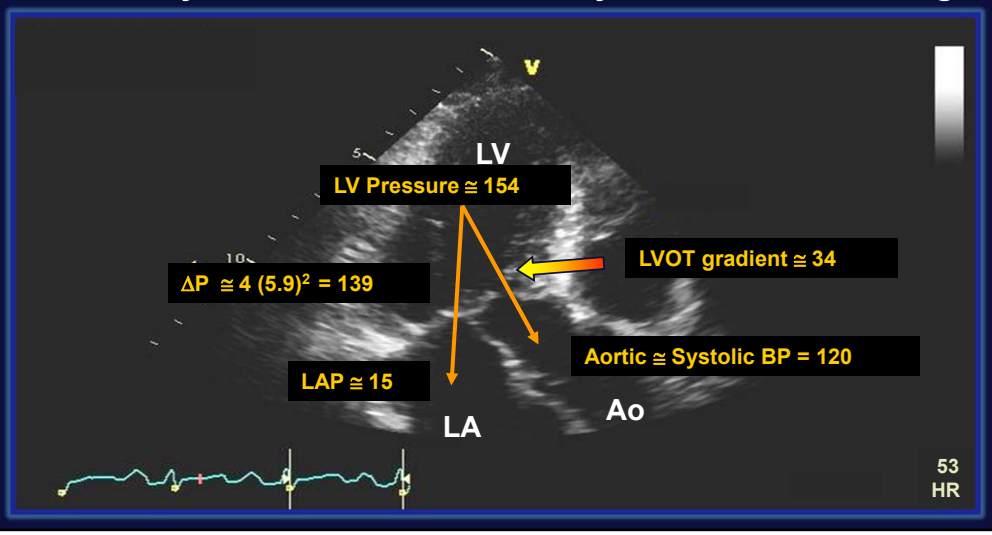
Identify of Location, Presence and Severity of Outflow Obstruction



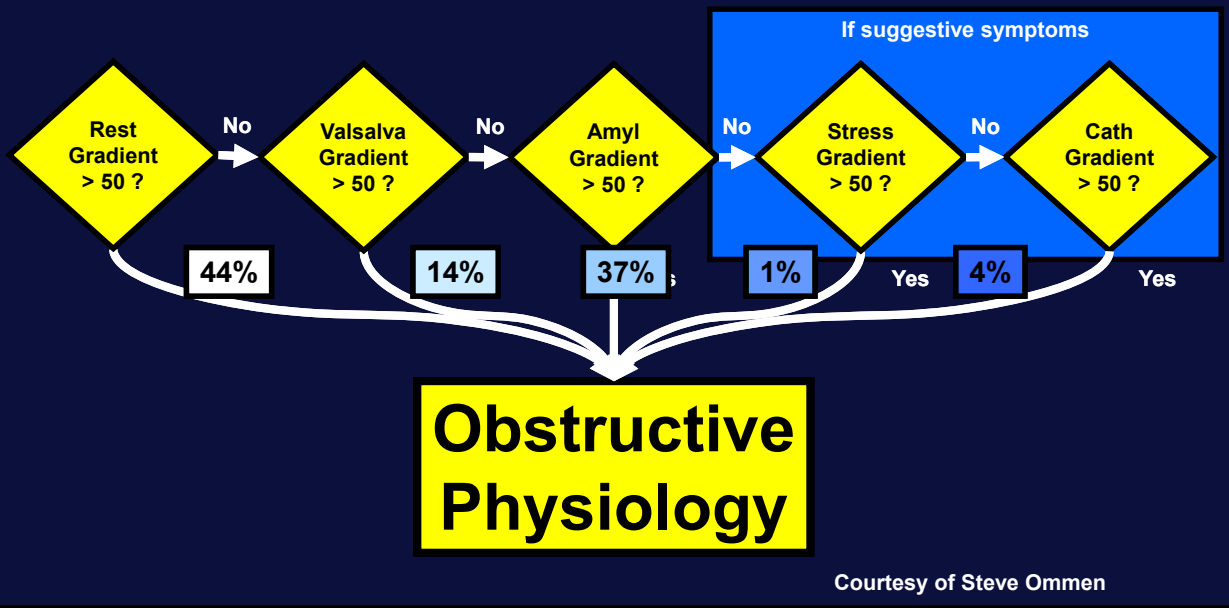
Estimating LVOT Gradient Using MR Peak Velocity

MR Velocity = 5.9 m/sec

Systolic BP = 120 mmHg

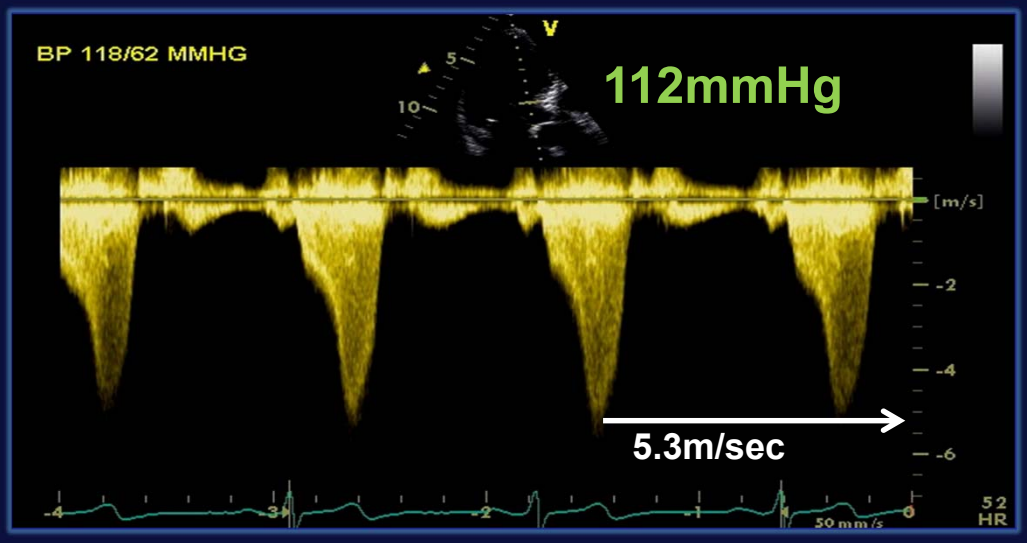


Pursuit of Obstruction



Courtesy of Steve Ommen

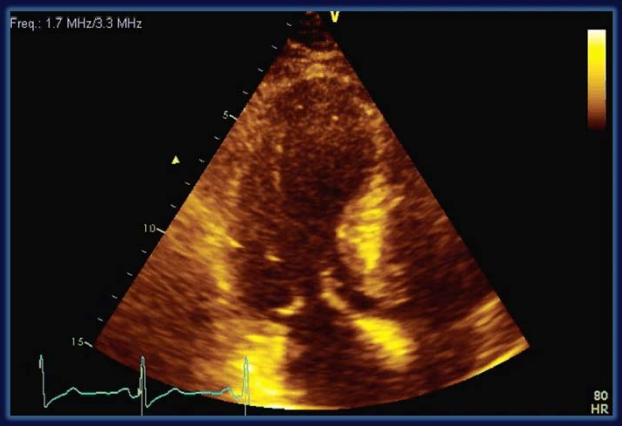
Gradient: Amyl Nitrite

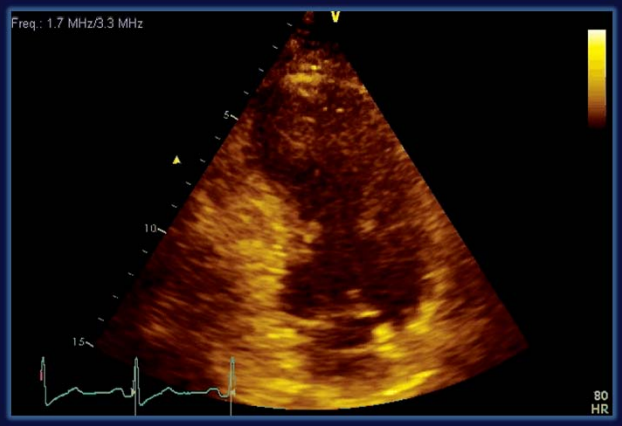


Case
Pursuit of Obstruction

- 58 year old male
- HCM, genotype + MYH7
- NYHA II-III; fatigue and SOB

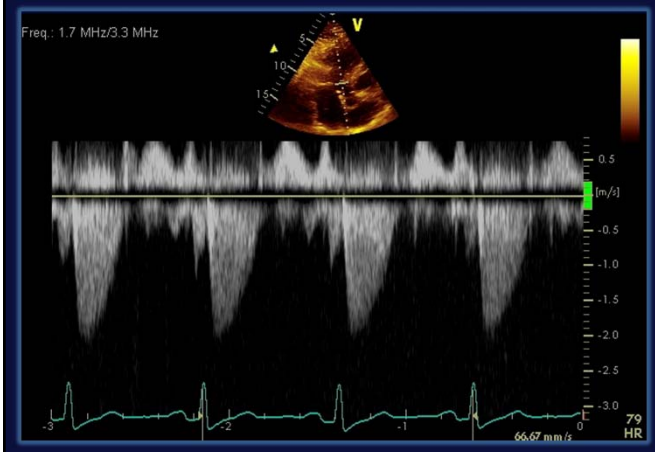
Transthoracic Echocardiogram



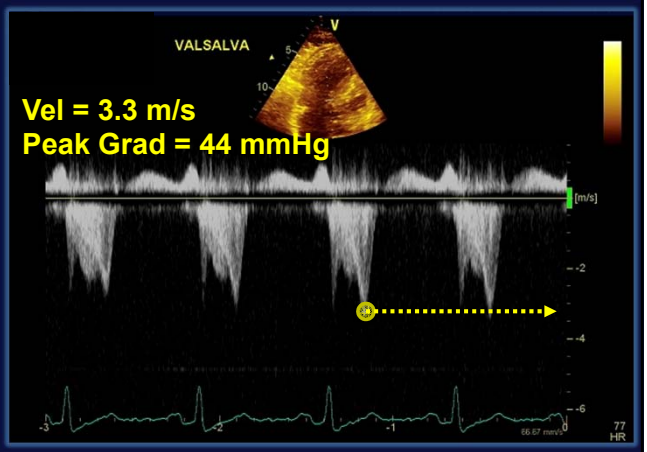


Continuous Wave Doppler

REST

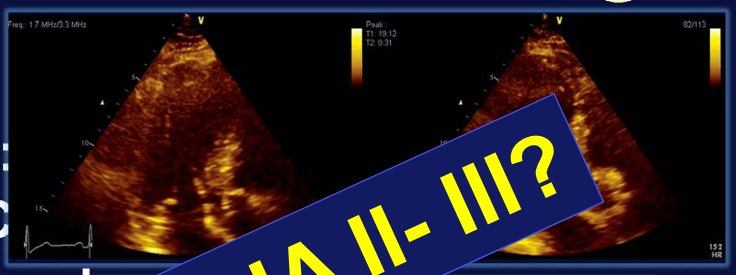


Strain Phase of Valsalva

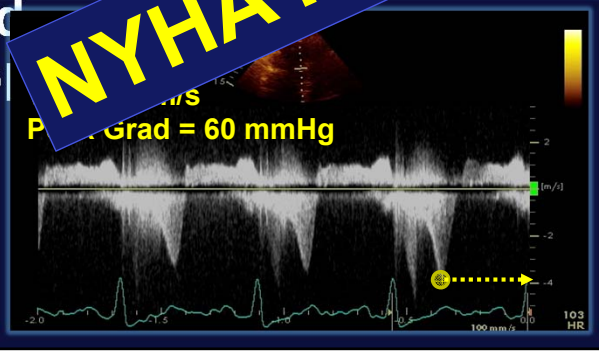


Stress Echocardiogram

- Bruce: 10:
- 118% FAC
- Normal blood pressure res

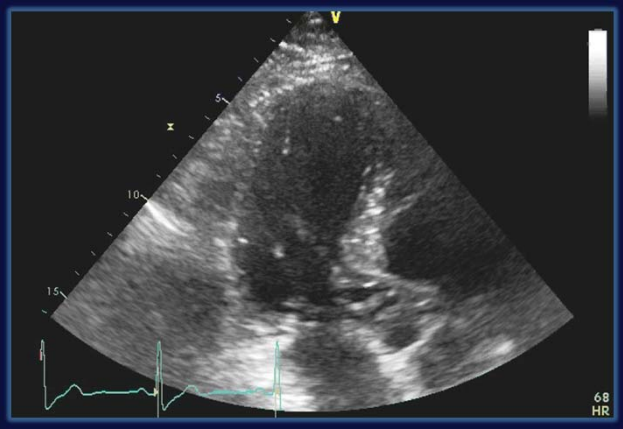


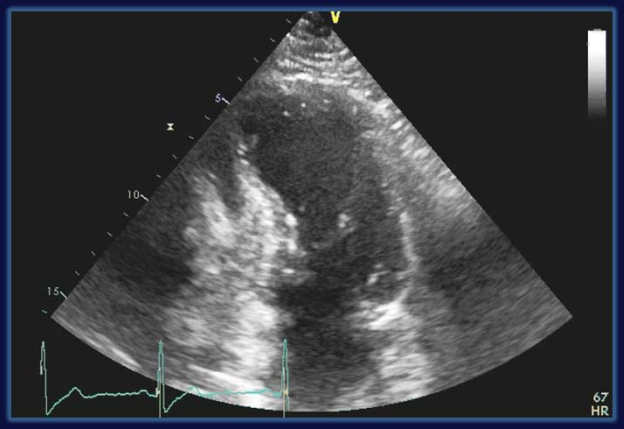
NYHA II- III?



3 Months Later

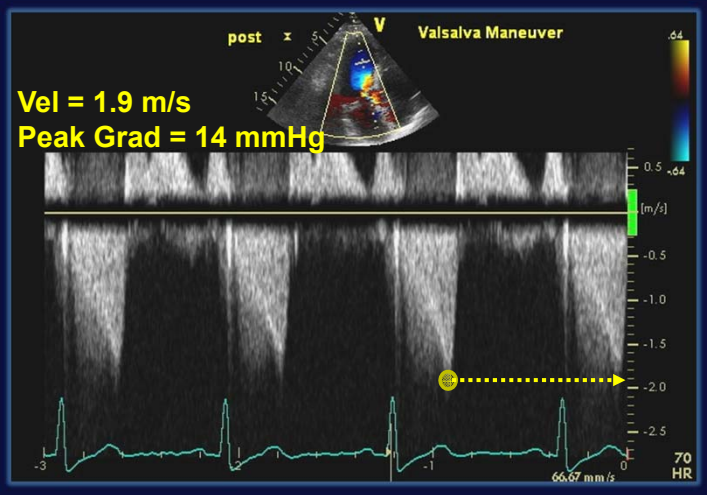
Unable to tolerate beta blocker, NYHA III





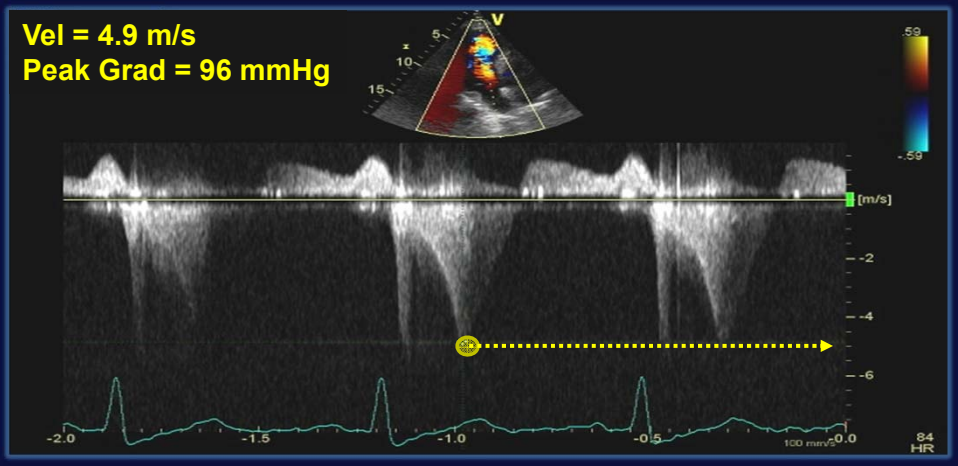
Continuous Wave Doppler

Strain Phase of Valsalva

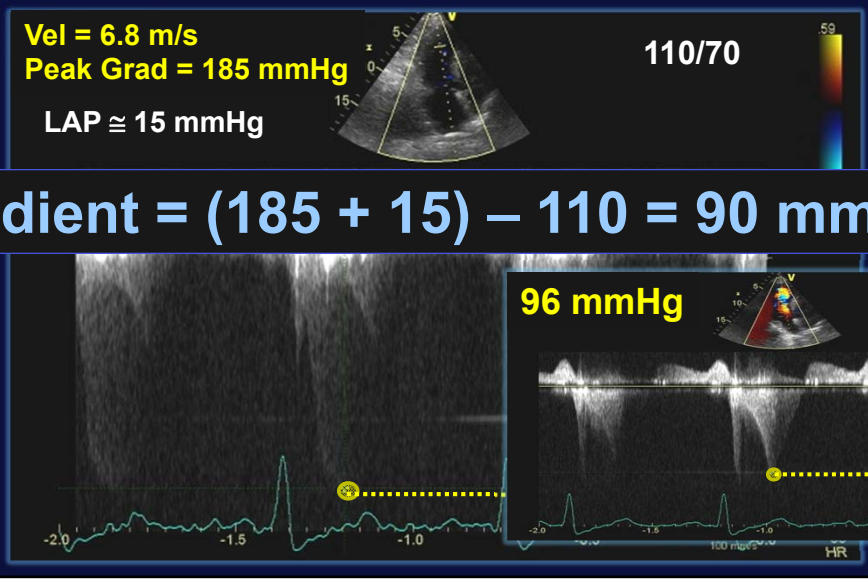


Continuous Wave Doppler
2 Hours Later

Strain Phase of Valsalva: Post Prandial



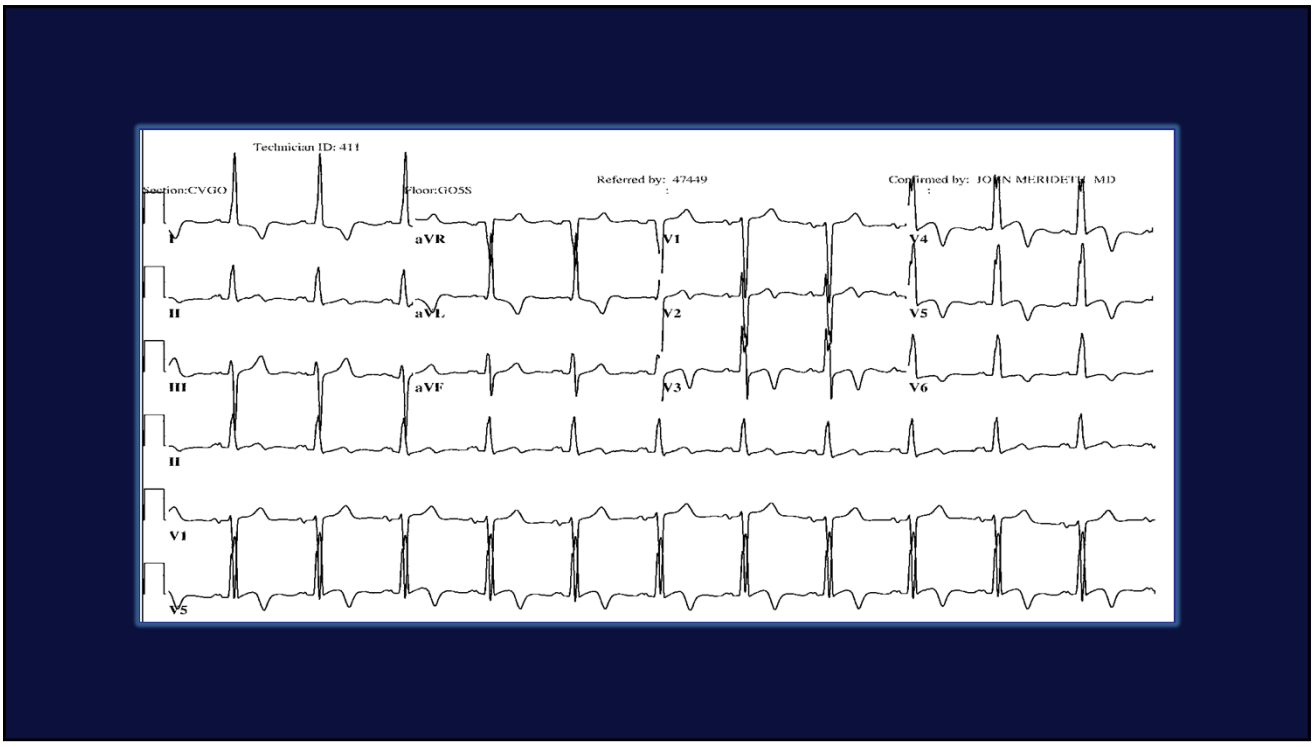
Mitral Regurgitation
2 Hours Later

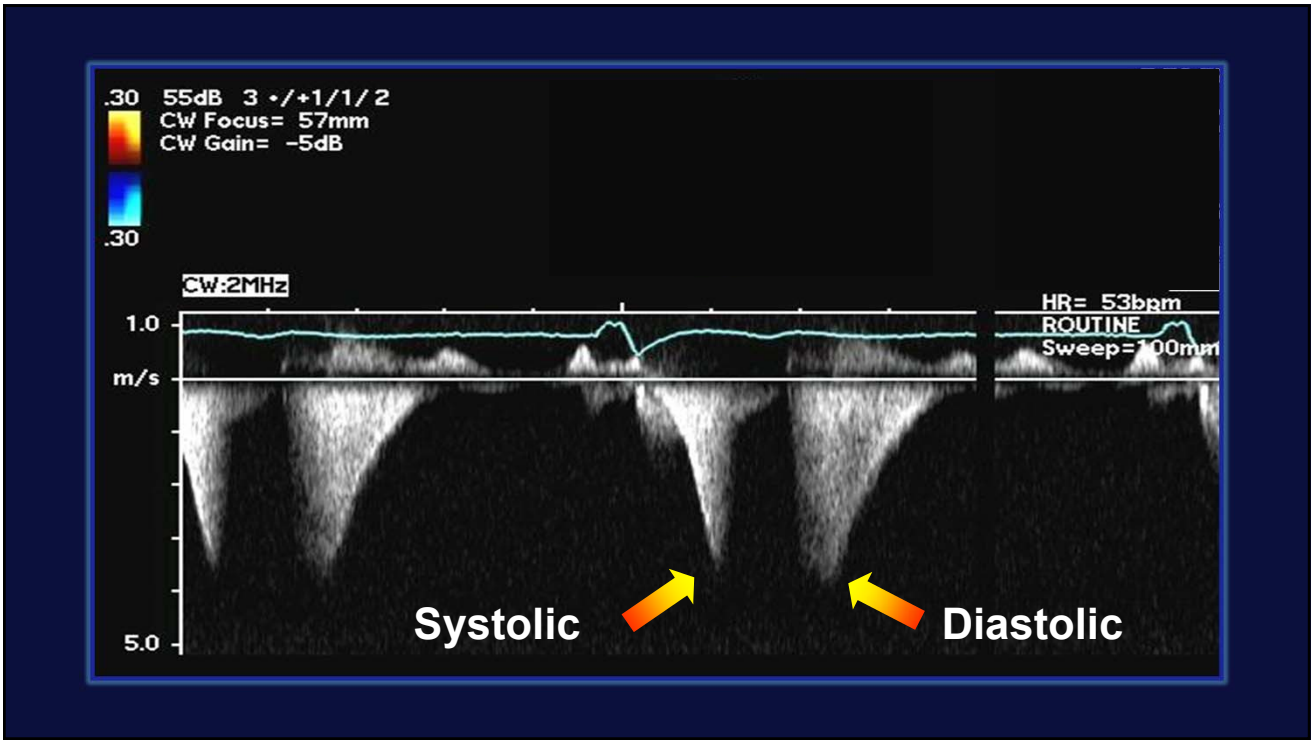


Gradient = (185 + 15) – 110 = 90 mmHg

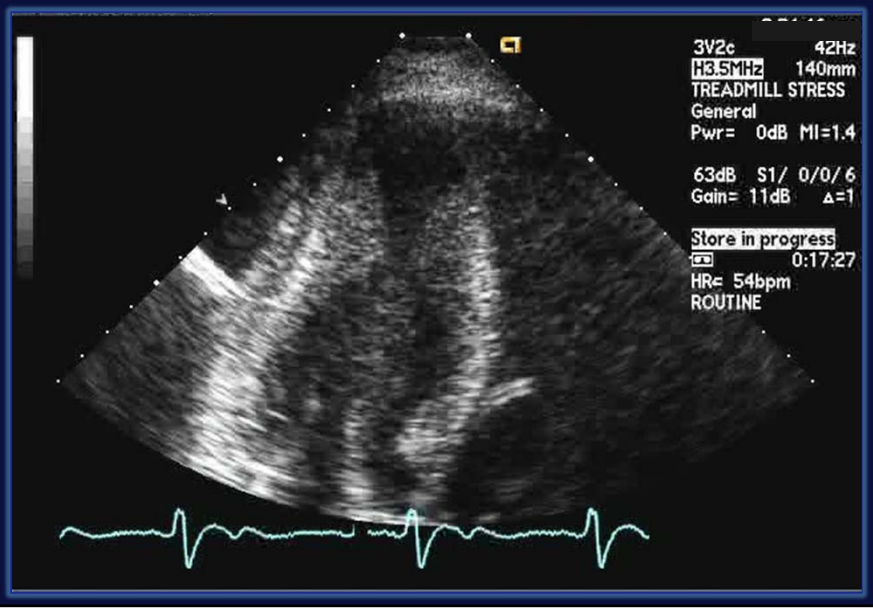
Case

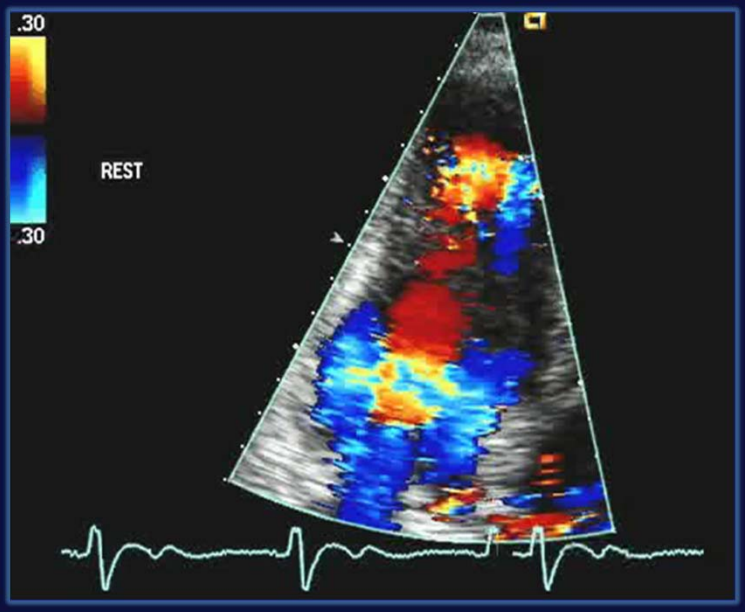
- 76 year old male
- Progressive dyspnea and fatigue with minimal exertion; angina when climbing stairs.
- Coronary Angiography: no obstructive epicardial coronary artery disease.


Technician ID: 411
Section:CVGO
Floor:GO5S
Referred by: 47449
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
V1
V5

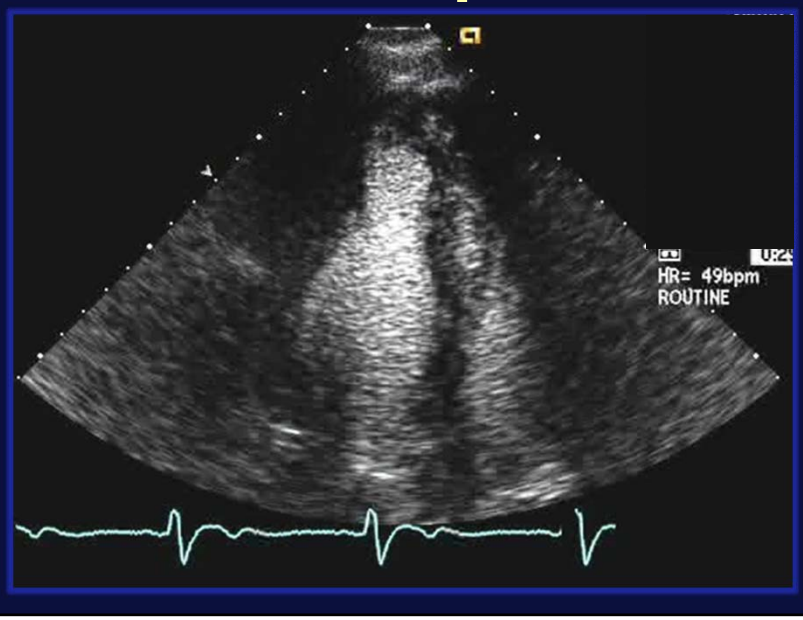

.30
55dB 3 •/+1/1/2
CW Focus= 57mm
CW Gain= -5dB
.30
CW:2MHz
1.0
m/s
5.0
HR= 53bpm
ROUTINE
Sweep=100mm
Systolic
Diastolic

Apical 4 Chamber View



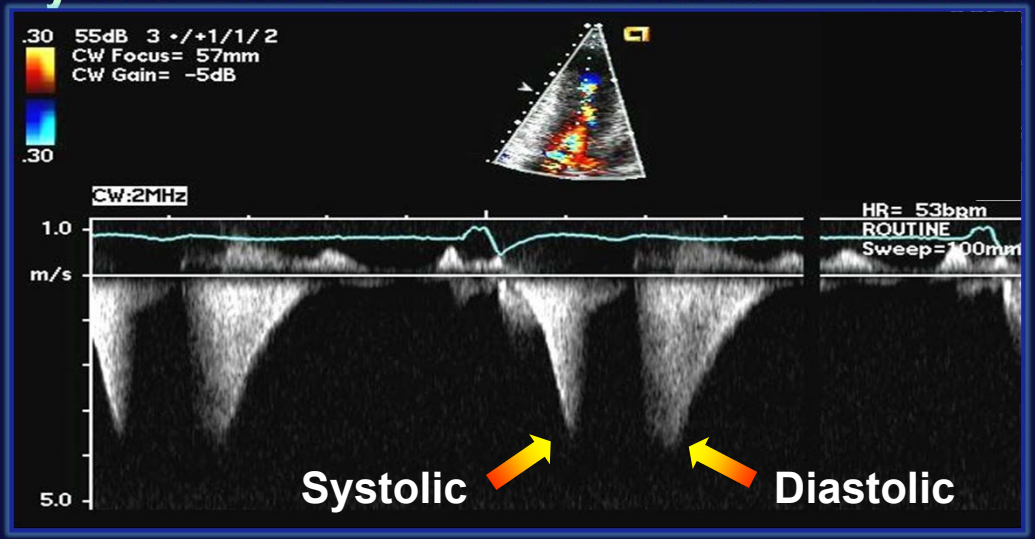


Apical HCM with Apical Aneurysm



Apical HCM with Apical Aneurysm

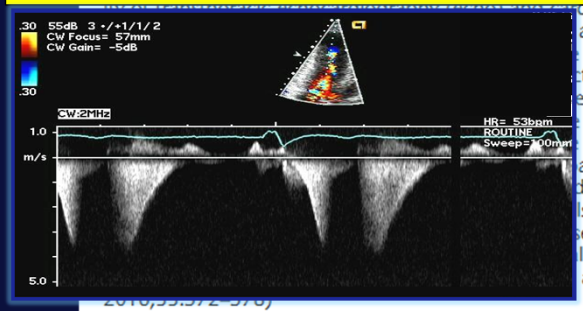
Early and Late Outflow Obstruction ~ 60 mmHg



The Incremental Value of Magnetic Resonance Imaging for Identification of Apical Pouch in Patients with Apical Variant of Hypertrophic Cardiomyopathy

Darko Vucicevic, M.D.,* Steven J. Lester, M.D.,* Christopher P. Appleton, M.D.,* Prasad M. Panse, M.D.,† John William Schleifer, M.D.,* and Susan Wilansky, M.D.*

- **Echo with an without contrast identified 8/17 (47%) of apical those with apical pouch noted on MRI.**
- **Echo missed 2 patients with an apical thrombus.**



diac magnetic resonance imaging (cMRI) to accu-
aneurysm in patients with aHCM. Methods: We
patients that had features of aHCM on imaging.
ted, and the ability of these diagnostic modalities
eurys
four
to accurately identify both aneurysms, but only
atients had apical thrombus that was identified by
dicate that cMRI is superior to echo in identifying
lso suggest that in patients undergoing echo, the
es the diagnostic yield. Further study is necessary
l pouch will be of clinical benefit for patients with
adverse cardiovascular events. (Echocardiography

Echocardiography 2016;33:572-578

Hypertrophic Cardiomyopathy Complicated by Apical Aneurysm

- **Apical abnormalities in apical HCM:**
  Pouch: 15%; Aneurysm: 3%
- **Adverse events associated with aneurysm (not apical pouch)**
  - **Progressive heart failure/death (18%)**
  - **SCD or revived cardiac arrest (14%)**
  - **Appropriate ICD discharge (11%)**
  - **Nonfatal embolic stroke (7%)**

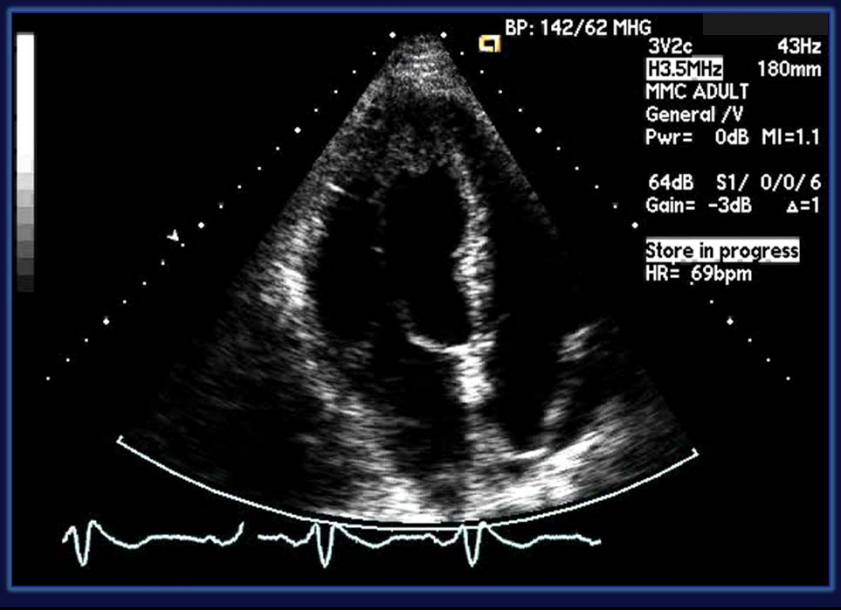
Binder J et al JASE 2011;24:775
Maron MS, et al. Circulation 2008;118:1541

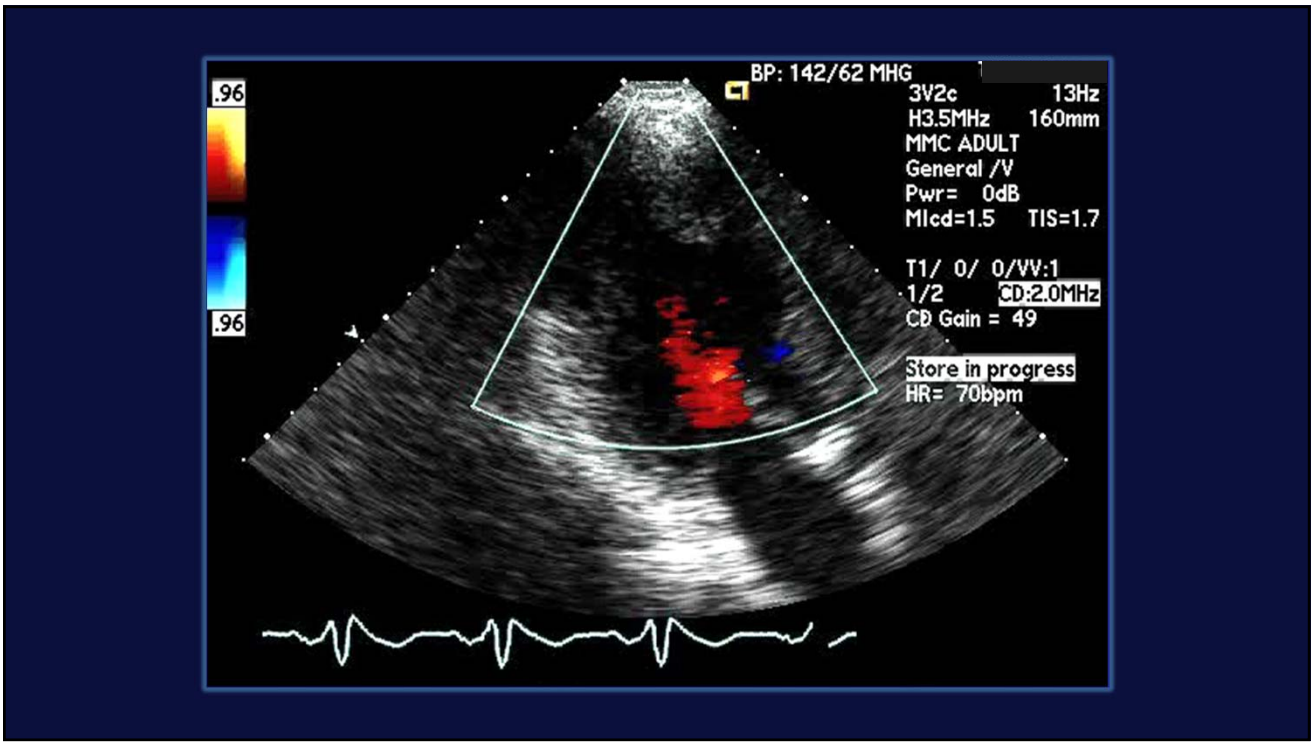
Cardiac Surgery

LV apical ventriculotomy:

Extended mid to apical myectomy, resection of apical aneurysm

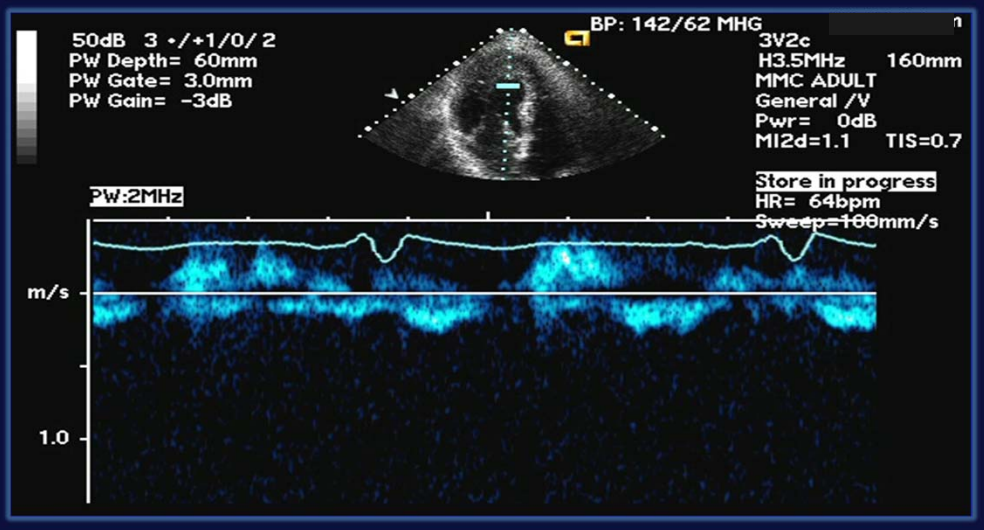
Post Op



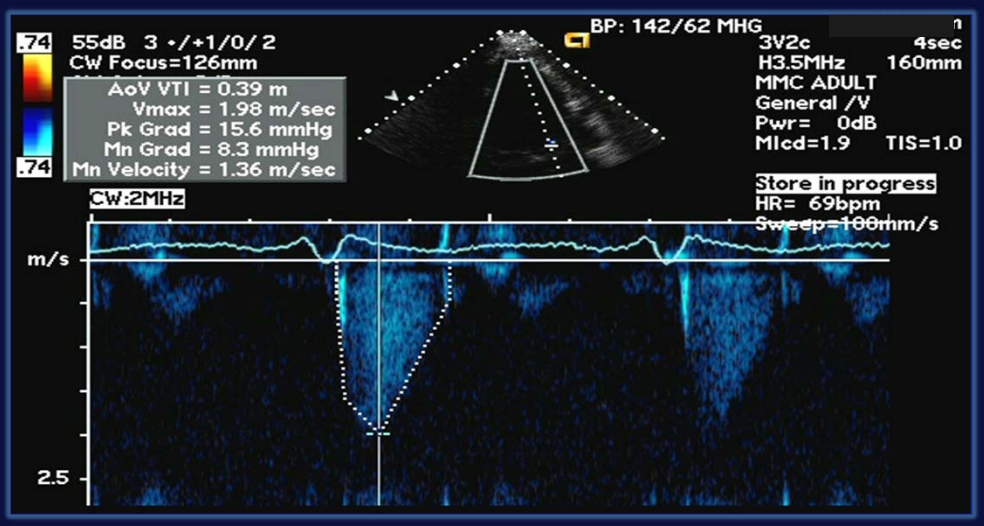


Continuous Wave Doppler

LV Apex



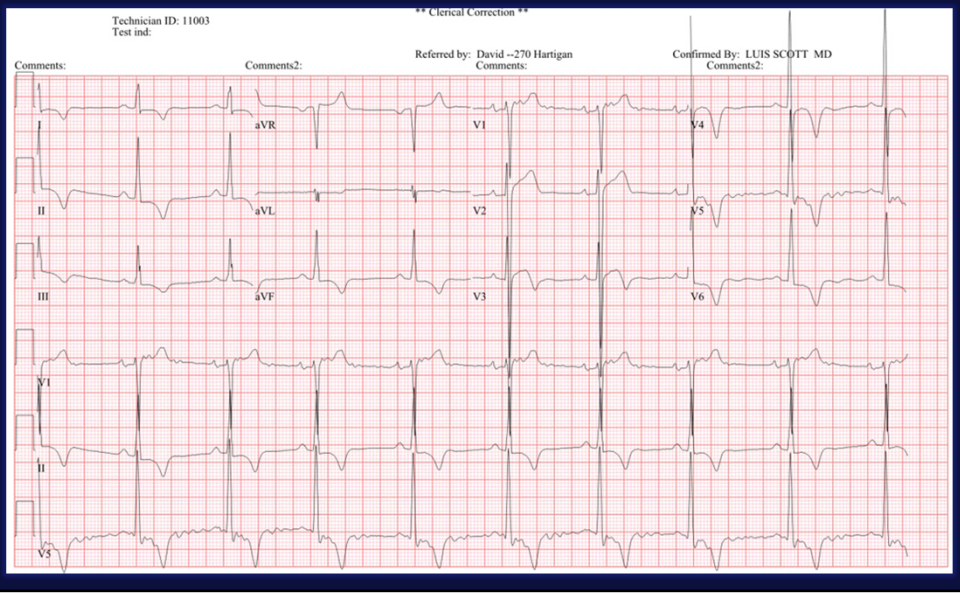
Continuous Wave Doppler
LVOT and Aortic Valve



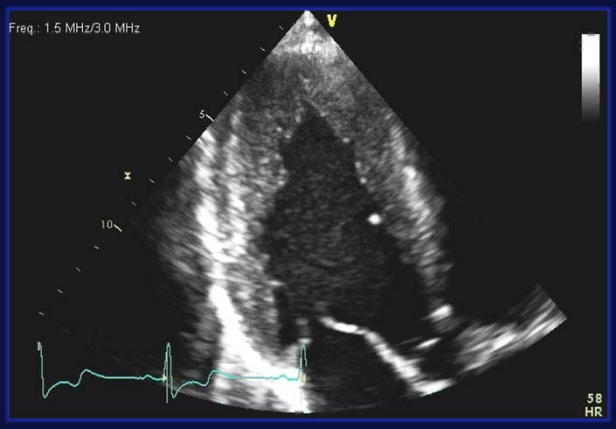
Case

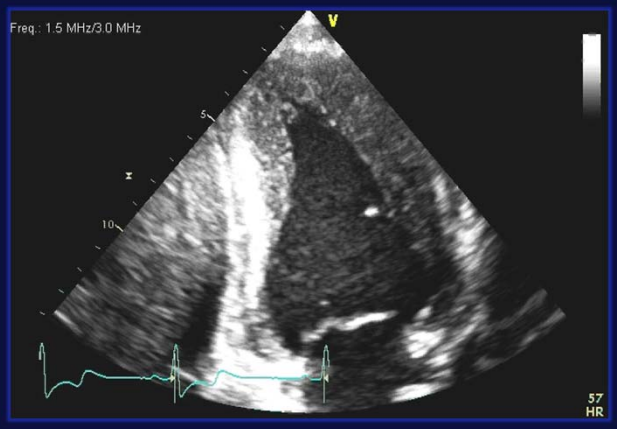
- 31 year old male
- Professional soccer player
- FIFA pre-season examination

Electrocardiogram

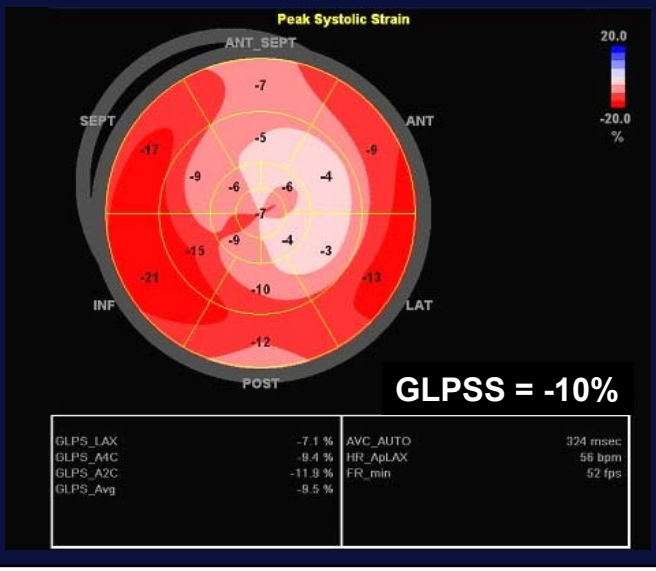


Transthoracic Echocardiogram



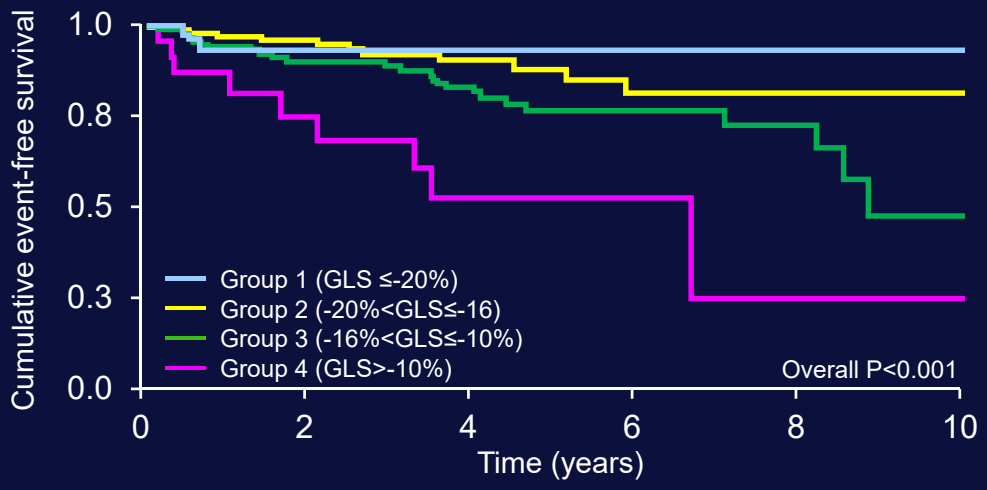


Global Longitudinal Peak Systolic Strain

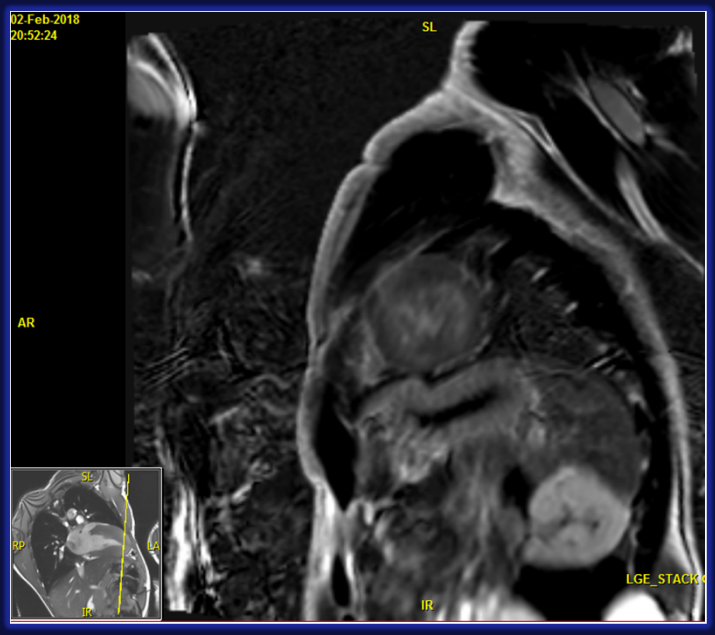


Hypertrophic Cardiomyopathy

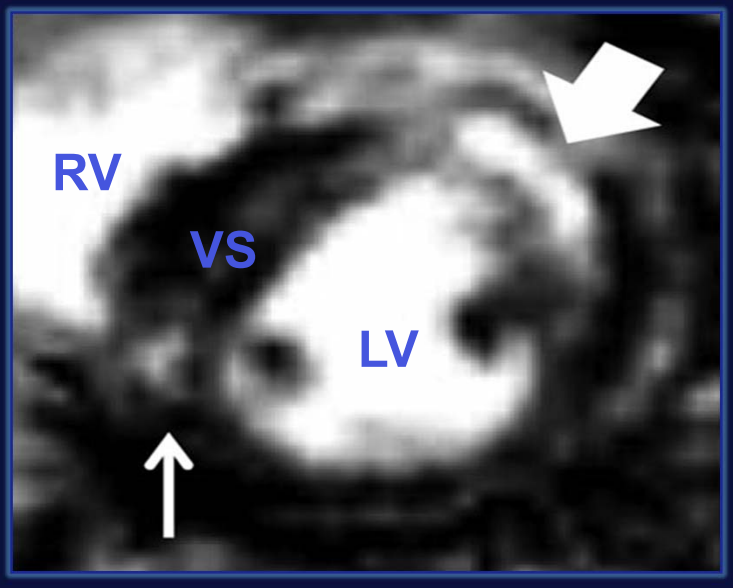
Global Longitudinal Strain and Event Free Survival



Liu et al. Am J Cardiol 2017;120(4):670-675

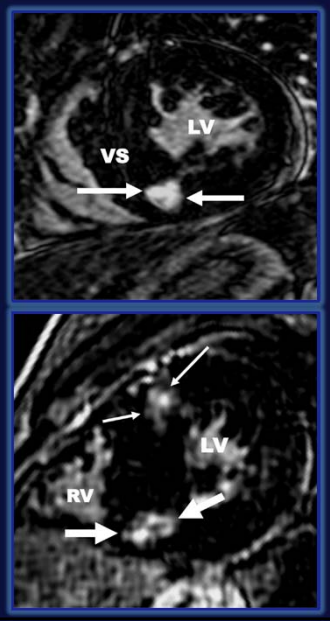


Late Gadolinium Enhancement



Bravo et al. European Heart Journal-Cardiovasc Imaging 2015

LGE: At RV Insertion Points



- Seen in isolation in about 10% of pts.
- On average affects only 3% of LV mass.
- Does not represent replacement fibrosis.
- This pattern of LGE in isolation appears to neither be associated with increased risk nor itself a marker for prognostic decision making.

Bravo et al. European Heart Journal-Cardiovasc Imaging 2015
Chan et al. Am J Cardiol 2015;

ORIGINAL ARTICLE

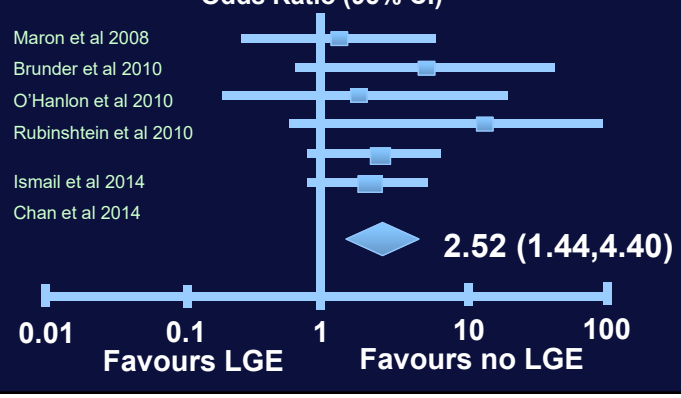
Myocardial fibrosis on cardiac magnetic resonance and cardiac outcomes in hypertrophic cardiomyopathy: a meta-analysis

Alexandros Briasoulis, Sagar Mallikethi-Reddy, Mohan Palla, Issa Alesh, Luis Afonso

Heart 2015;0:1–6

Sudden Cardiac Death

Fibrosis (1653 pts) vs No Fibrosis (1414 pts)

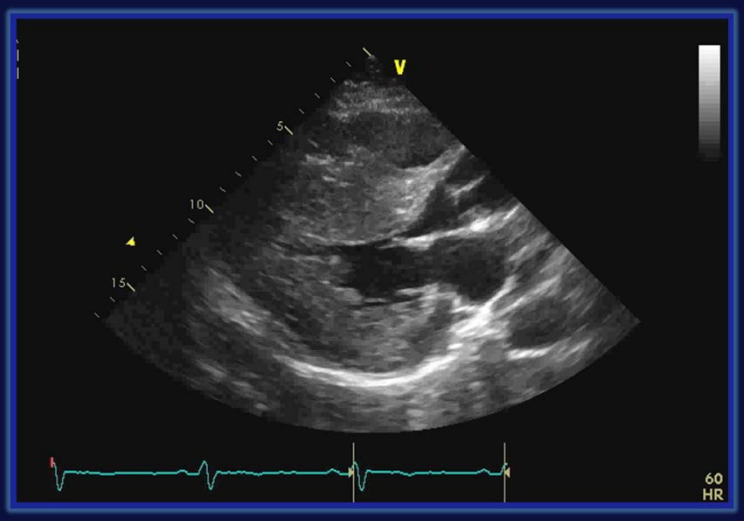


Case

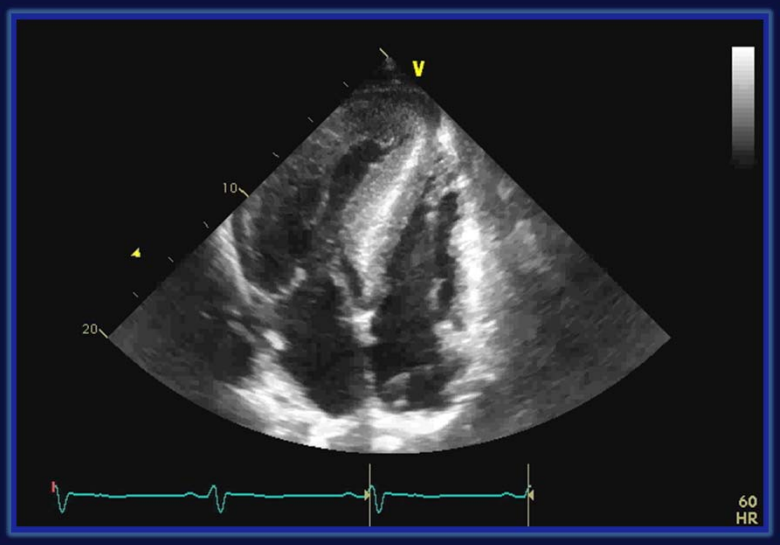
- 53 year old male
- No family Hx of HCM
- NYHA III (SOB and fatigue)
- Effort related presyncope

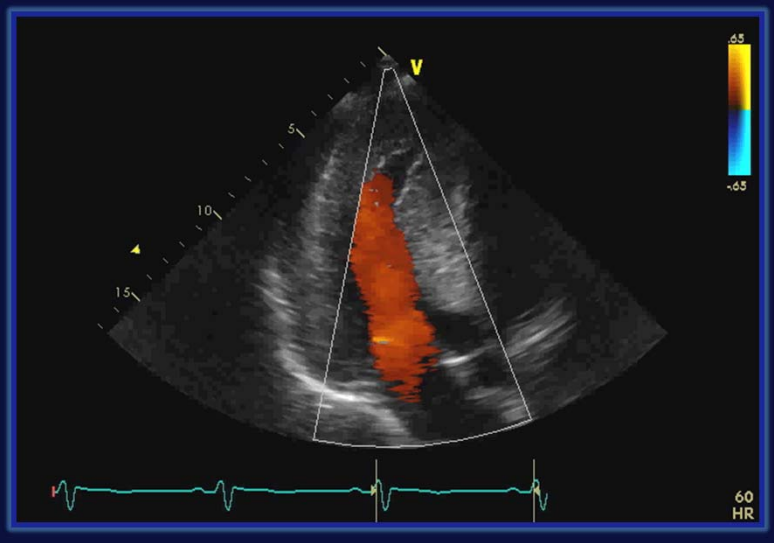
EDD 37 mm; ESD 19mm

Septum 25 mm; posterior wall 24 mm

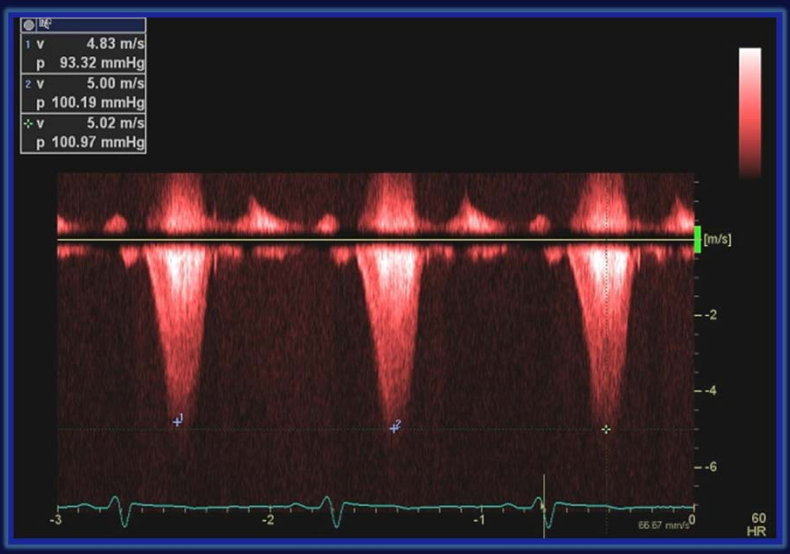


EF 68% LAVI 48 cc/m^2

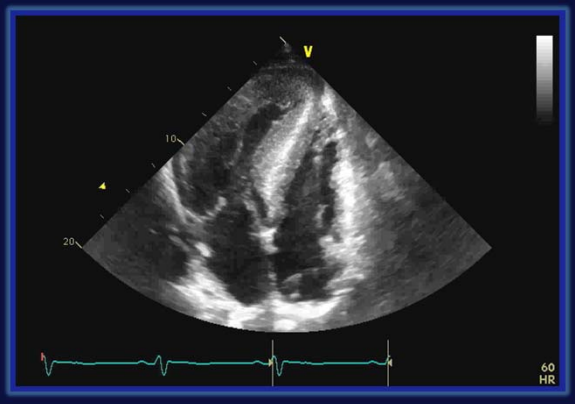


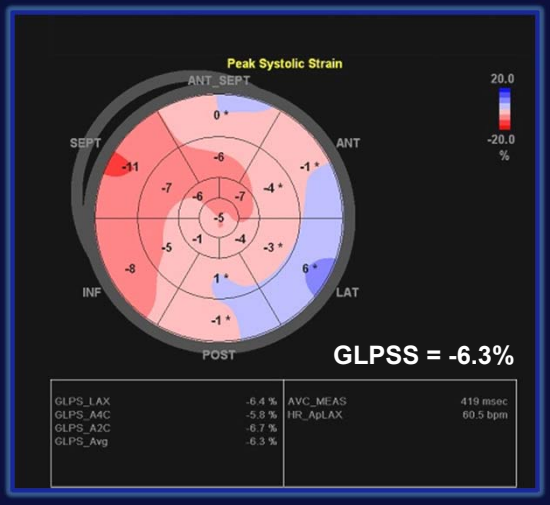


Mid LV gradient 100 mmHg



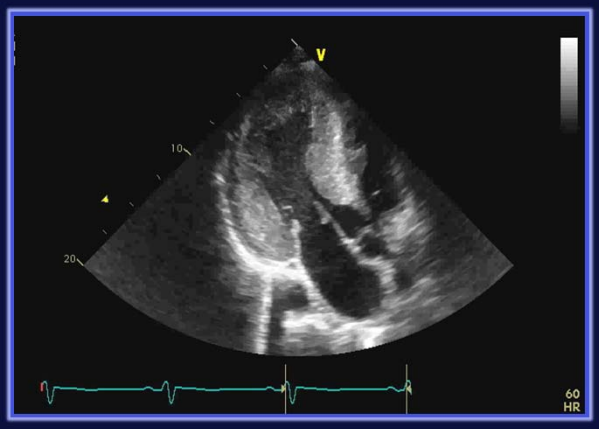
Apical 4 Chamber & Global Longitudinal Peak Systolic Strain



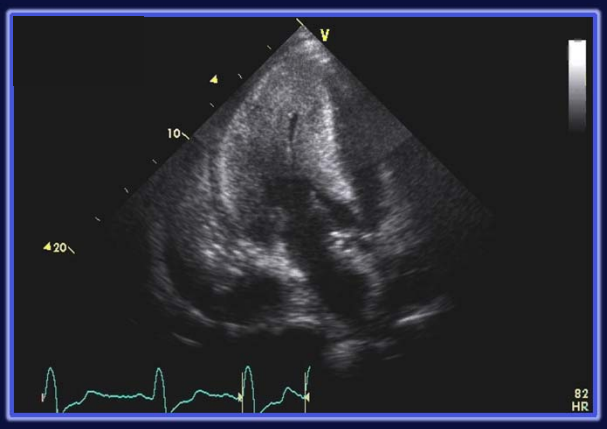


Surgical Myectomy

Pre op



Post op



Diagnosis?

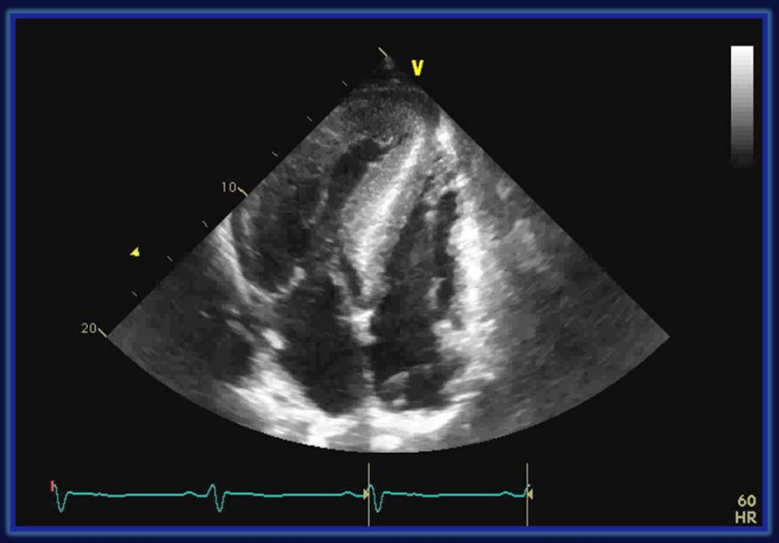
1. Hypertrophic cardiomyopathy
2. Amyloid heart disease
3. Fabry's disease
4. Danon disease
5. Need more information

Additional Testing

Cardiac MRI (outside)

- **Corroborated echo morphologic findings**
- **“some delayed enhancement at the LV lateral wall in addition to the septum at the RV insertion site”.**

“Some delayed enhancement in the lateral wall and RV insertion site”



Fabry's Disease Testing

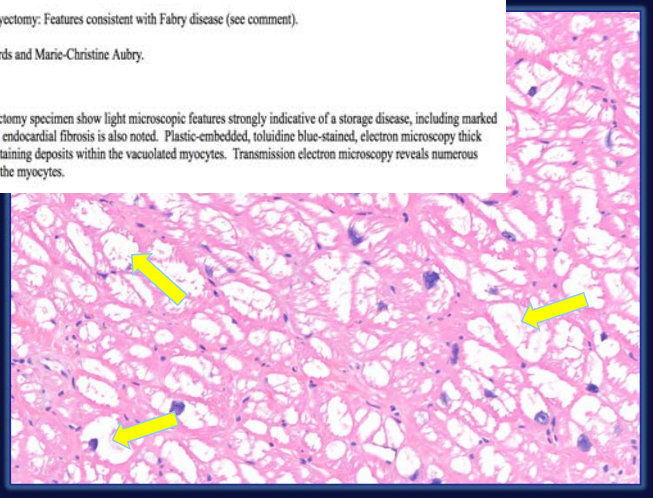
1. Serum alpha-galactosidase level:
   - 0.03 (0.6-3.63)
2. Genetic Testing
   - G373S variant of GLA

Myocyte Hypertrophy and Vacuolization

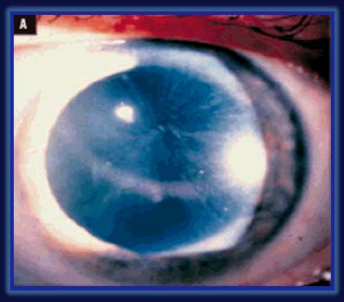
Final Diagnosis:
A. Heart, left ventricle, septal myectomy: Features consistent with Fabry disease (see comment).

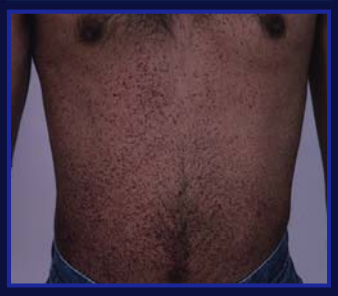
Seen with Drs. William D. Edwards and Marie-Christine Aubry.

Diagnosis Comment:
Tissue sections of the septal myectomy specimen show light microscopic features strongly indicative of a storage disease, including marked sarcoplasmic vacuolization. Mild endocardial fibrosis is also noted. Plastic-embedded, toluidine blue-stained, electron microscopy thick sections show numerous darkly-staining deposits within the vacuolated myocytes. Transmission electron microscopy reveals numerous lamellar bodies contained within the myocytes.



Clinical Manifestations





Whorl-like corneal opacifications

Angiokeratomas

Progressive renal disease

CNS (CVA and TIA)

Acroparesthesias

Anhidrosis

Ped Neph 2004;19:583

Ped Neph 2004;19:583

Fabry's Disease

Mutations in the GLA gene

↘

Provides instructions for making an enzyme called alpha-galactosidase A (αGLA)

↘

αGLA is active in lysosomes and breaks down a fatty substance globotriaosylceramide

↘

Globotriaosylceramide builds up in cells throughout the body

Fabry's Disease

- X-linked
- Often affects women despite being x-linked
- Mutations that decreased but do not eliminate the enzyme activity usually cause the milder, late-onset of disease that affect only the heart or kidneys

Prevalence of Anderson-Fabry Disease in Male Patients With Late Onset Hypertrophic Cardiomyopathy

B. Sachdev, MRCP; T. Takenaka, MD, PhD; H. Teraguchi, MD; C. Tei, MD, PhD; P. Lee, MRCP, MD, PhD; W.J. McKenna, MBBS, FRCP, FESC; P.M. Elliott, MBBS, MD, MRCP

Circulation 2002;105:1407-11

- 5 of 79 patients (6.3%) diagnosed at ≥ 40 years had Anderson-Fabry disease.
- 1 of 74 patients (1.4%) diagnosed at < 40 years had Anderson-Fabry disease.

Prevalence of Anderson-Fabry Disease in Male Patients With Late Onset Hypertrophic Cardiomyopathy

B. Sachdev, MRCP; T. Takenaka, MD, PhD; H. Teraguchi, MD; C. Tei, MD, PhD; P. Lee, MRCP, MD, PhD; W.J. McKenna, MBBS, FRCP, FESC; P.M. Elliott, MBBS, MD, MRCP

Circulation 2002;105:1407-11

Clinical Implications

- Male patients with concentric hypertrophy and no family history of HCM or inheritance consistent with X-linked disease should be screened for Anderson-Fabry disease.
- Correct diagnosis is important and treatment may stabilize and even for some reverse some cardiovascular manifestations.

Recombinant *α* galactosidase *Rx*

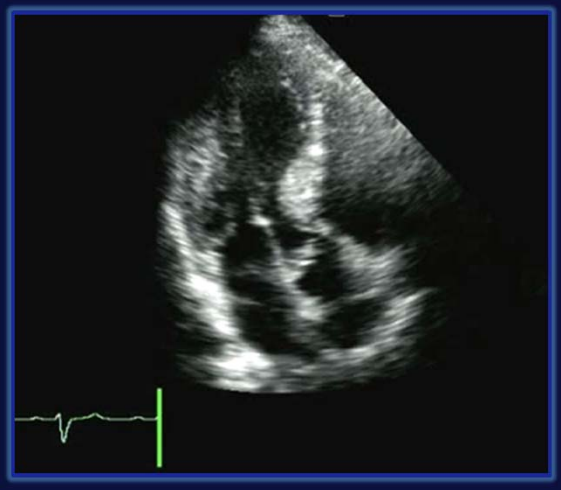
- IV infusion enzyme replacement therapy reduces glycosphingolipid tissue deposition
- Can reverse wall thickness and mass

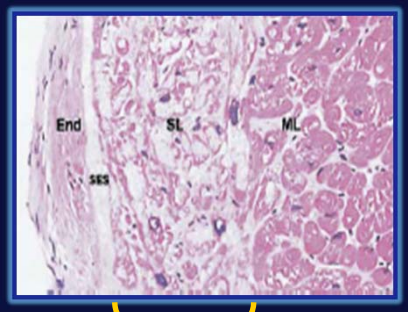
NEJM 2001; Vol345#1:9

Eur J Clin Investig 2004; 34 (12):838.

70 y/o Man: Dyspnea on exertion

Fabry Disease (Alpha-Galactosidase A Deficiency)





Glycosphingolipid Accumulation

Hyper-refractile subendocardial border:
94% Sensitive
100% Specific

Pieroni M, et al. JACC 2006; 47: 1663

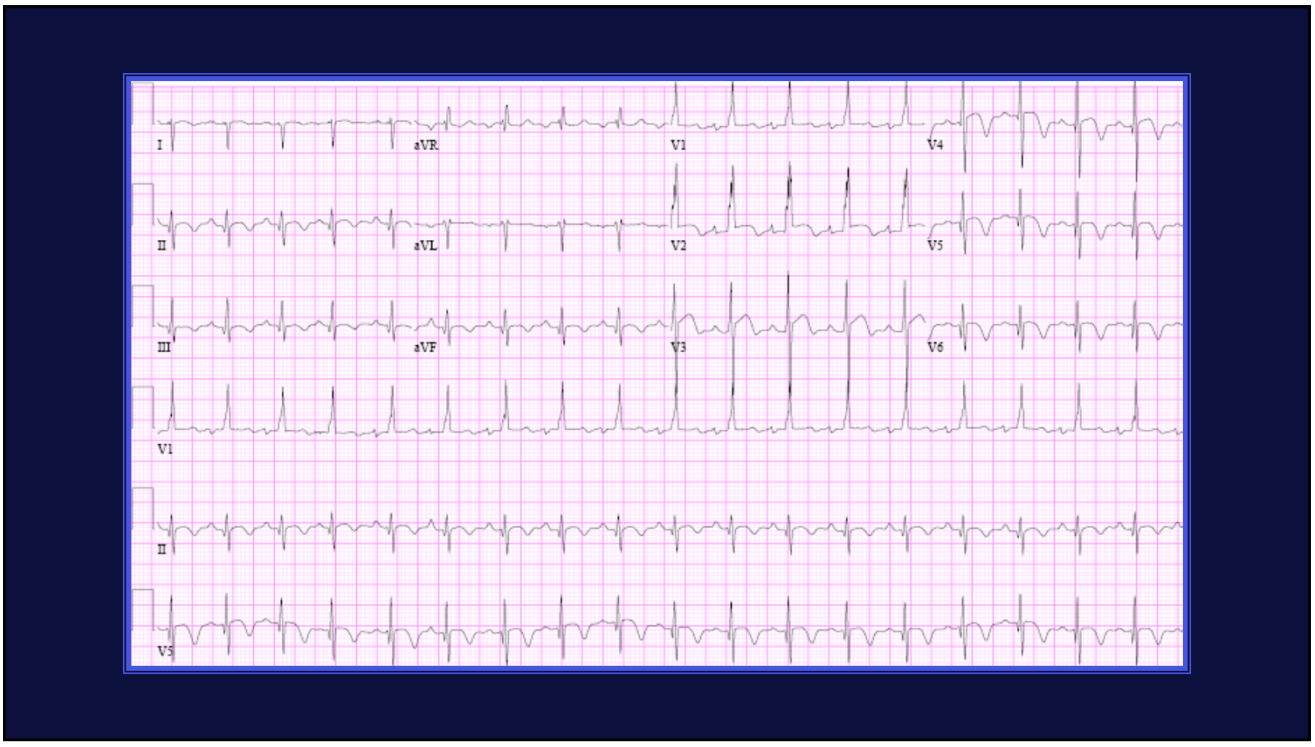
Courtesy Dr Bill Freeman

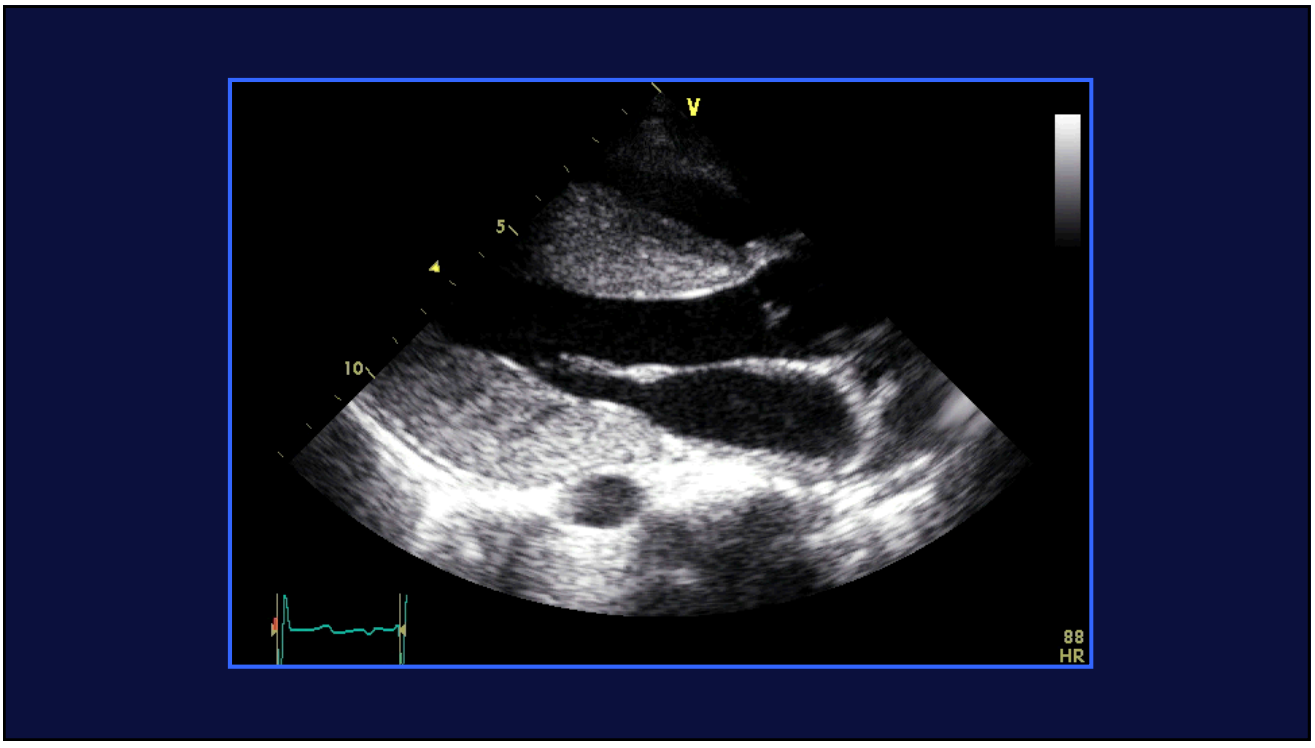
Case

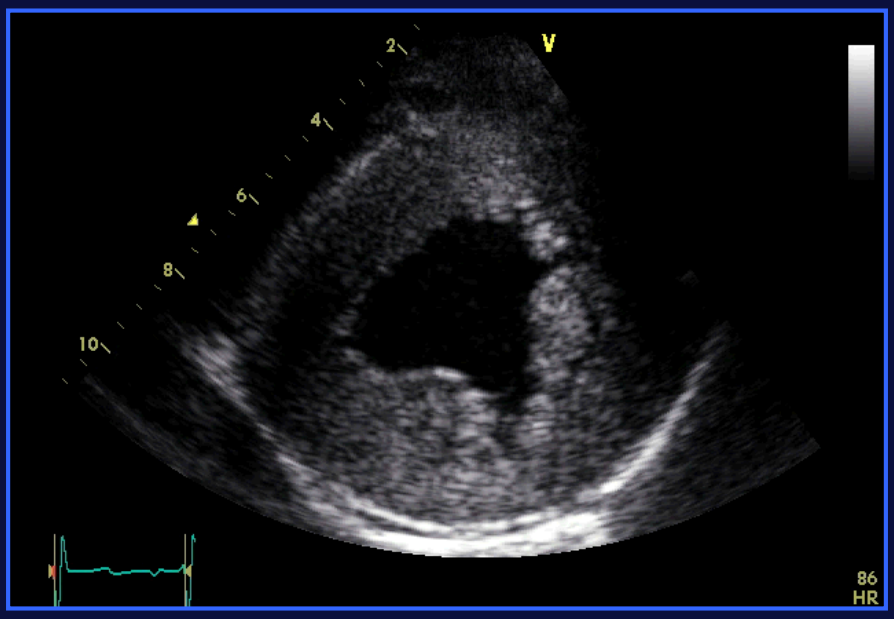
19 y/o male

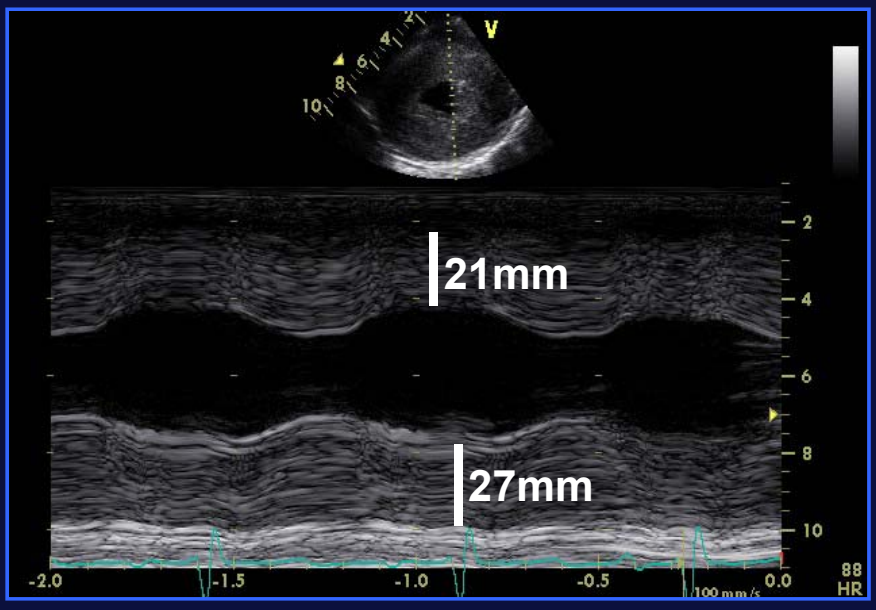
Wheelchair

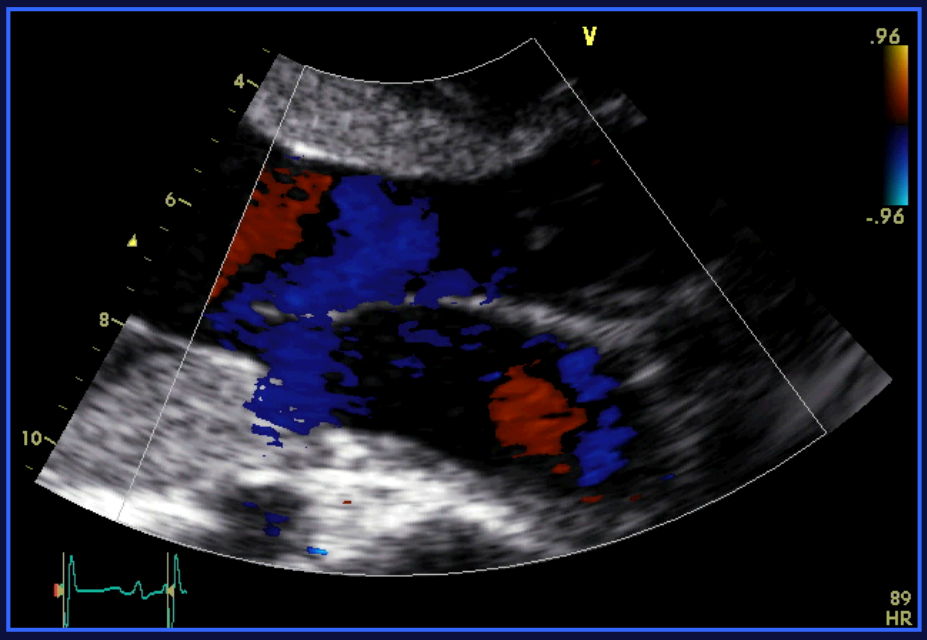
Post-prandial chest pain


I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
V1
II
V5

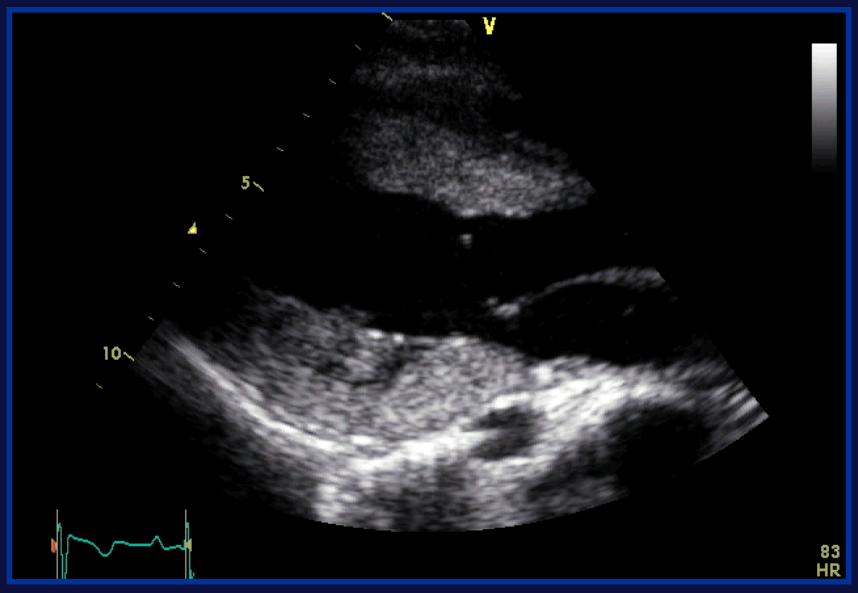

V
5
10
88
HR


V
2
4
6
8
10
86
HR


V
21mm
27mm
-2.0
-1.5
-1.0
-0.5
0.0
100 mm/s
88
HR

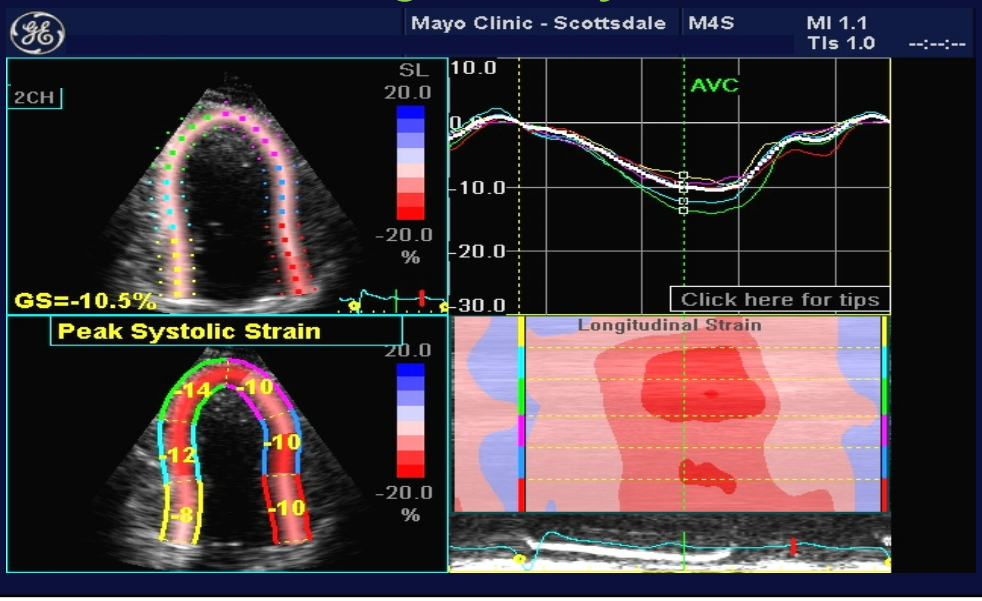


Papillary Muscle Prominence



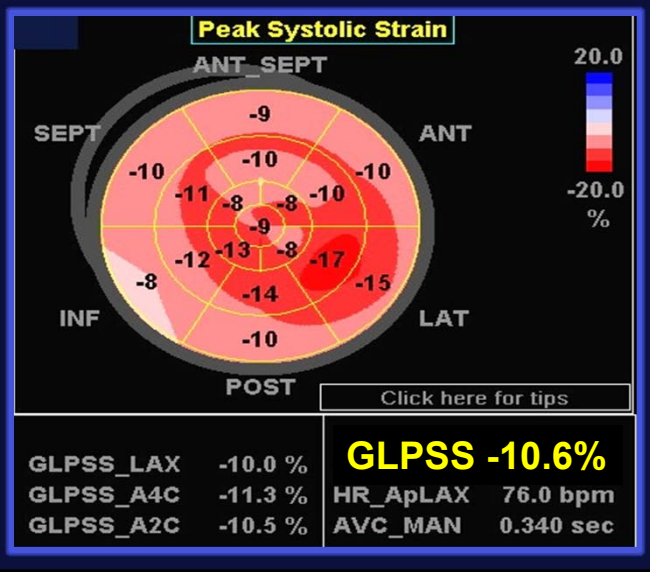
2D Feature Tracking

Global Average Peak Systolic Strain



2D Feature Tracking

Global Average Peak Systolic Strain



Why the Thick Walls?

1. Hypertrophy(genetic)
2. Infiltrative
3. Storage

Friedreich's Ataxia

- Symmetrically hypertrophied LV
- Prominent Papillary Muscle
- Absence of SAM

Clinical/Genetic Abnormalities in Friedrich's Ataxia

NEJM 1996 335: 1169

- Autosomal recessive neurodegenerative disorder
- 1:50,000
- Ataxia, cerebellar dysarthria, areflexia
- Onset < 20years; relentless course

Echocardiography

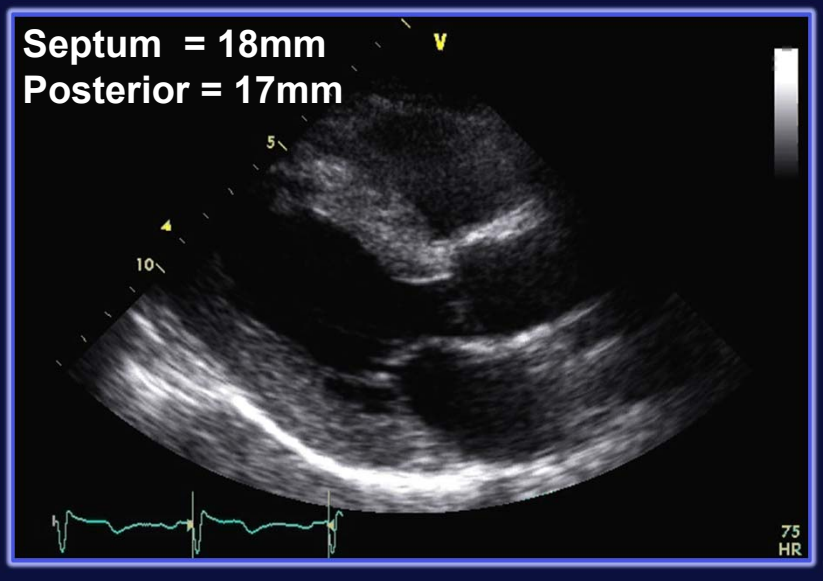
- Left ventricular hypertrophy (asymmetric)
- Thickened papillary muscles
- Reduced peak systolic velocity (TDI)
- Reduced E'

Circulation 2000; 102:1276
Eur J.Echo 2005; 6:243

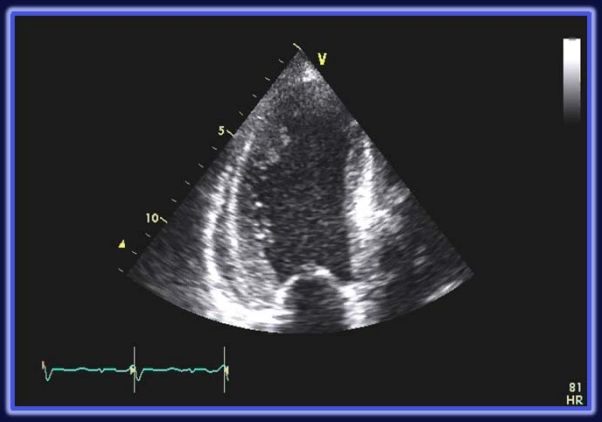
Case

- 67 y/o male status post myectomy 3 years prior
- NYHA III, Neuropathy

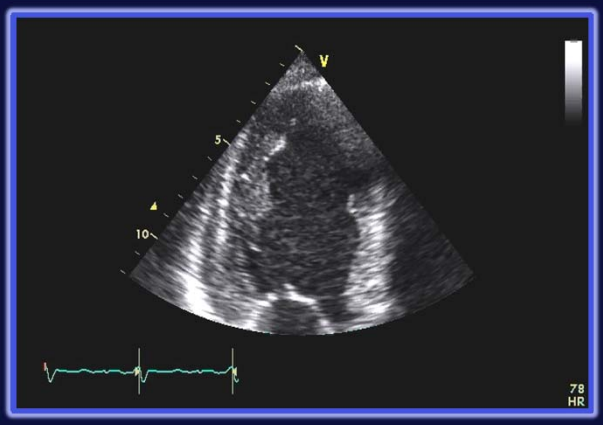
PLAX



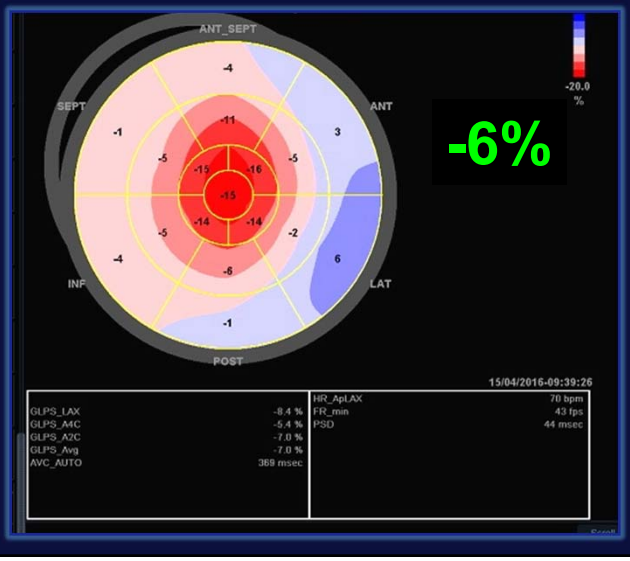
A4C



A3C



Global Longitudinal Peak Systolic Strain



Pathology Specimen

- Myocyte distribution not consistent with HCM
- Staining ATTR +

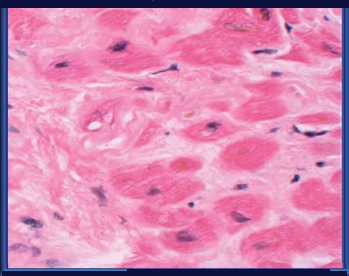
Pathology Specimen

FAMILIAL AMYLOIDOSIS

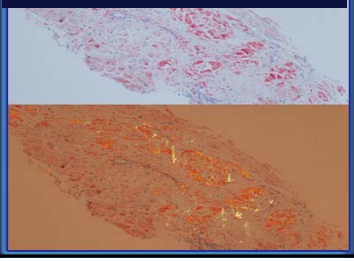
- Myocyte distribution not consistent with HCM
- Staining TTR +

Amyloidosis

Hematoxylin & Eosin



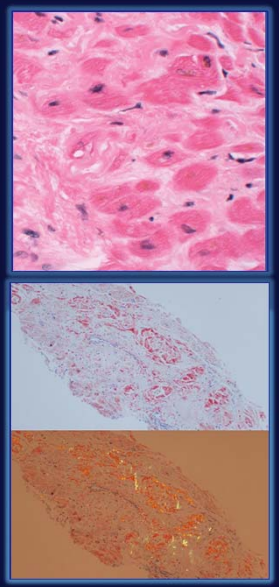
Sulfated Alcian Blue



The amyloidoses are a group of disorders characterized by the deposition of an extracellular proteinaceous material known as amyloid.

Falk Circulation. 2011;124:1079-1085

Amyloidosis



Classification / Subtypes

AL : Amyloid Light chain

ATTR : Amyloid Transthyretin

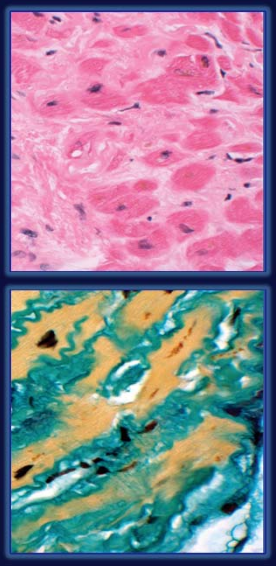
- ATTRm : mutated (familial)
- ATTRw : wild-type (senile)

AA : Amyloid Serum Amyloid A

A…. : at least 25 proteins

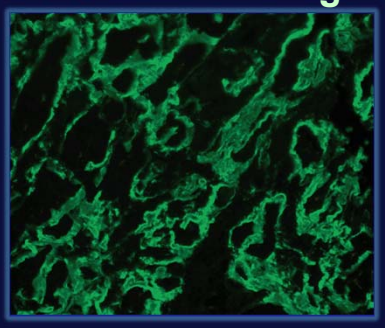
Falk Circulation. 2011;124:1079-1085

Amyloidosis



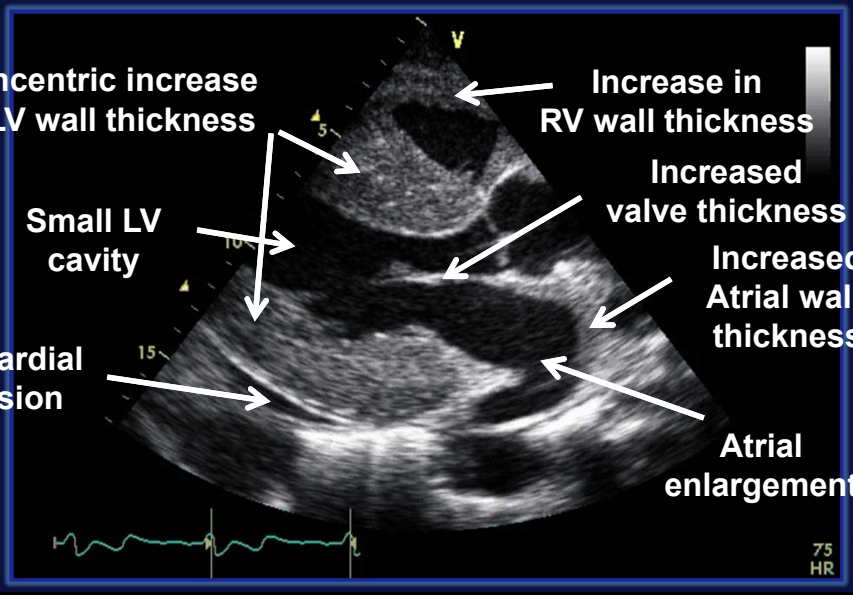
The type of protein that is misfolded and the organ or tissue in which the misfolded proteins (amyloids) are deposited determines the clinical manifestations of amyloidosis.

Immunostaining

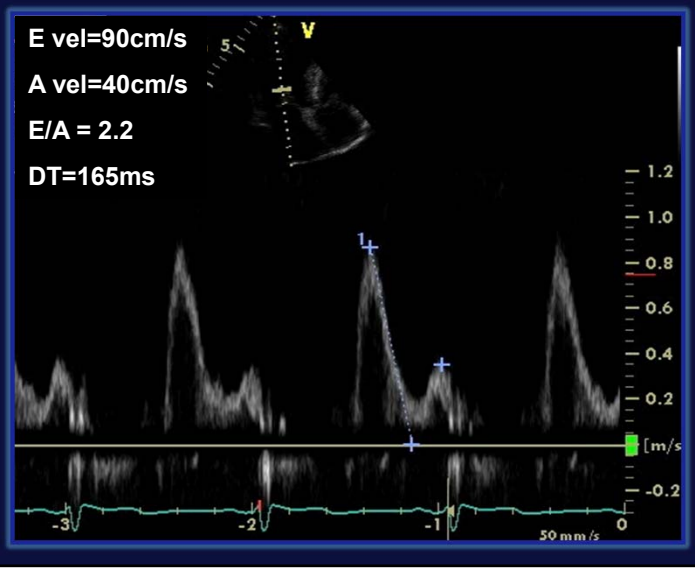


Falk Circulation. 2011;124:1079-1085

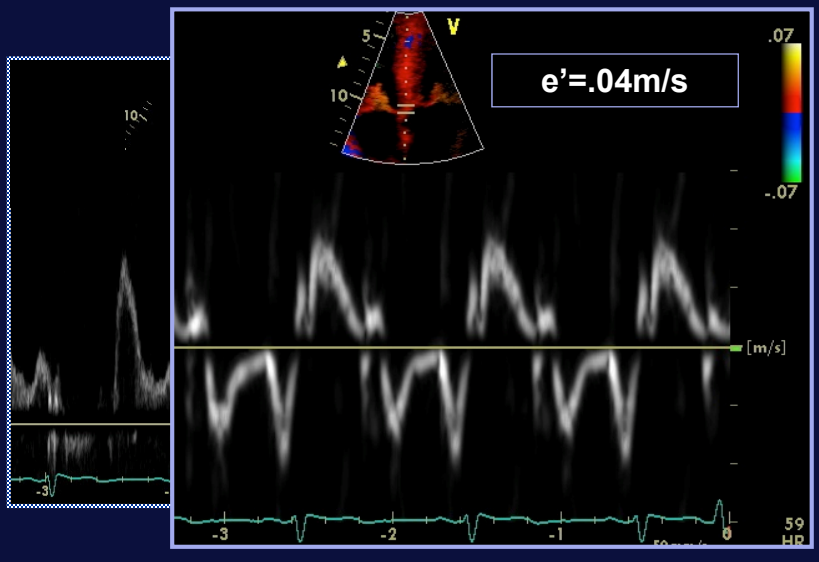
Amyloidosis
2D Echocardiography



Left Ventricular Function
Diastole



E/e'= 22



Grading LV Filling Pressures

E/A = 2.2, E/e', LAVI, TRV

- E/A ≤ 0.8 + E ≤ 50cm/s → Normal LAP, Grade I DD
- E/A ≤ 0.8 + E ≥ 50 cm/ OR E/A > 0.8 - < 2 → **Rule of 2's**
  1. Av E/e' > 14
  2. TR > 2.8 m/s
  3. LA vol > 34 cc/m^2
- E/A ≥ 2 → Grade III DD

"So that the coming together depends on the going apart; the systole depends on the diastole; the flow depends on the ebb."

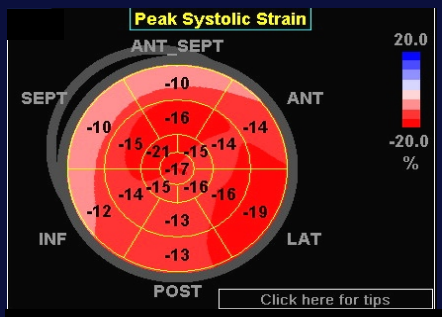
D.H. Lawrence

ASE/EACVI GUIDELINES AND STANDARDS

Recommendations for the Evaluation of Left Ventricular Diastolic Function by Echocardiography: An Update from the American Society of Echocardiography and the European Association of Cardiovascular Imaging

Sherif F. Nagueh, Chair, MD, FASE,[1] Otto A. Smiseth, Co-Chair, MD, PhD,[2] Christopher P. Appleton, MD,[3] Benjamin F. Byrd, III, MD, FASE,[4] Hisham Dokainish, MD, FASE,[1] Thor Edvardsen, MD, PhD,[5] Frank A. Flachskampf, MD, PhD, FESC,[6] Thierry C. Gillebert, MD, PhD, FESC,[7] Allan L. Klein, MD, FASE,[1] Patrizio Lancellotti, MD, PhD, FESC,[8] Paolo Marino, MD, FESC,[9] Jae K. Oh, MD,[3] Bogdan Alexandru Popescu, MD, PhD, FESC, FASE,[2] and Alan D. Waggoner, MHS, RDCS[4], *Houston, Texas; Oslo, Norway; Phoenix, Arizona; Nashville, Tennessee; Hamilton, Ontario, Canada; Uppsala, Sweden; Ghent and Liège, Belgium; Cleveland, Ohio; Novara, Italy; Rochester, Minnesota; Bucharest, Romania; and St. Louis, Missouri*

(J Am Soc Echocardiogr 2016;29:277-314.)



GLPSS Avg = -14.3%

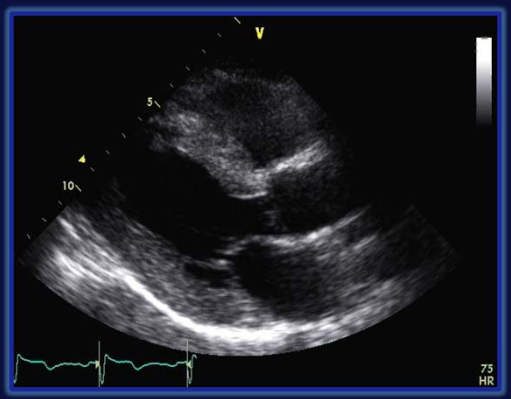
" abnormal LV systolic longitudinal function can be detected…the finding of impaired GLS and reduced s' velocity can be used as an indication of myocardial dysfunction".

Left Ventricular Function

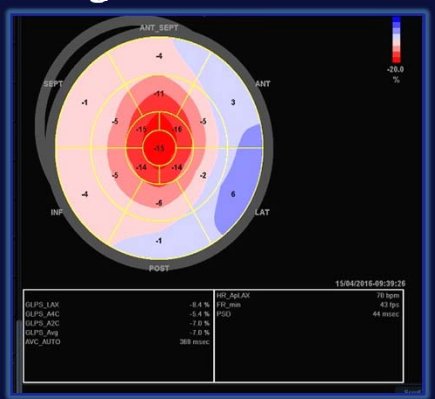
Systole

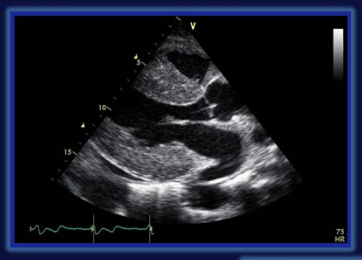
67 year old male post myectomy

Radial Function

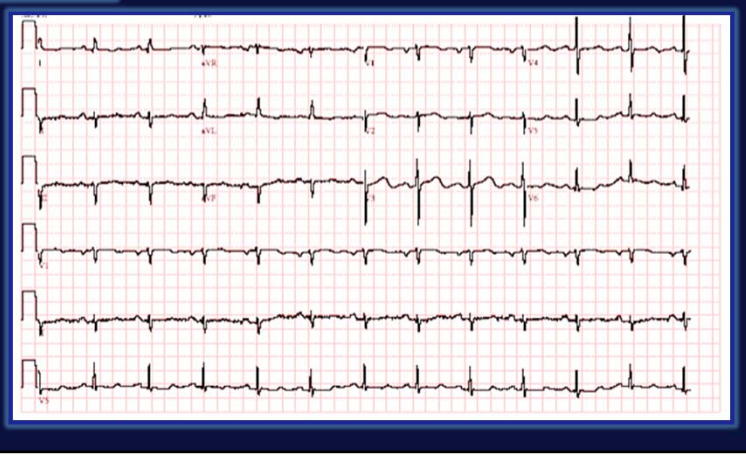


Longitudinal Function





Electrocardiogram



Amyloidosis
Laboratory Approach to Diagnosis

- **Monoclonal Protein Study (Serum and Protein)**
- **Immunoglobulin Free Light Chains (Serum)**
- **Subcutaneous Fat Aspirate (with Congo Red)**

ECHO / MRI
Pyrophosphate Scan
BNP
Troponin

Subcutaneous fat aspirate is negative but clinician still has high index of suspicion

Subcutaneous fat aspirate is positive for amyloid deposits

Specific organ biopsy

Diagnostic for amyloidosis

Negative

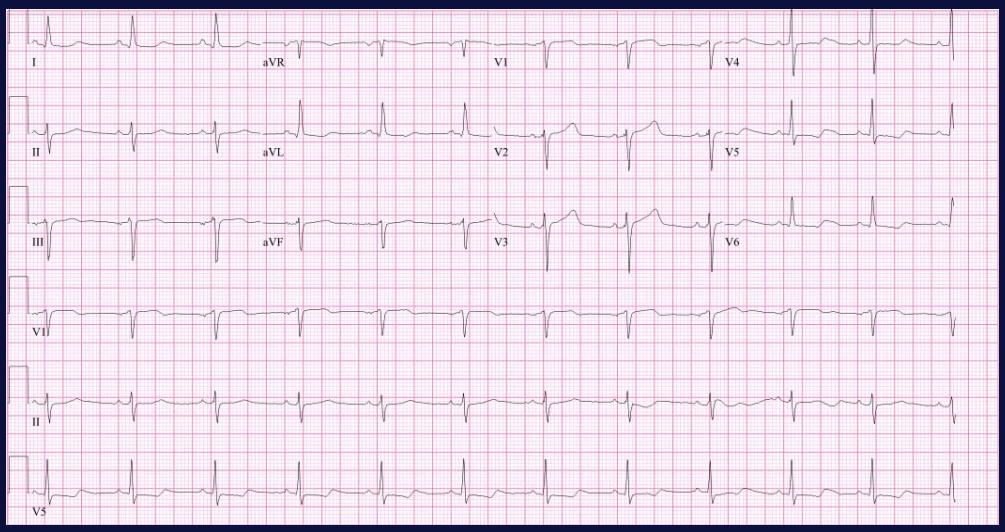
Positive

To identify the type of amyloid protein: Consult (hematology / surgical path)

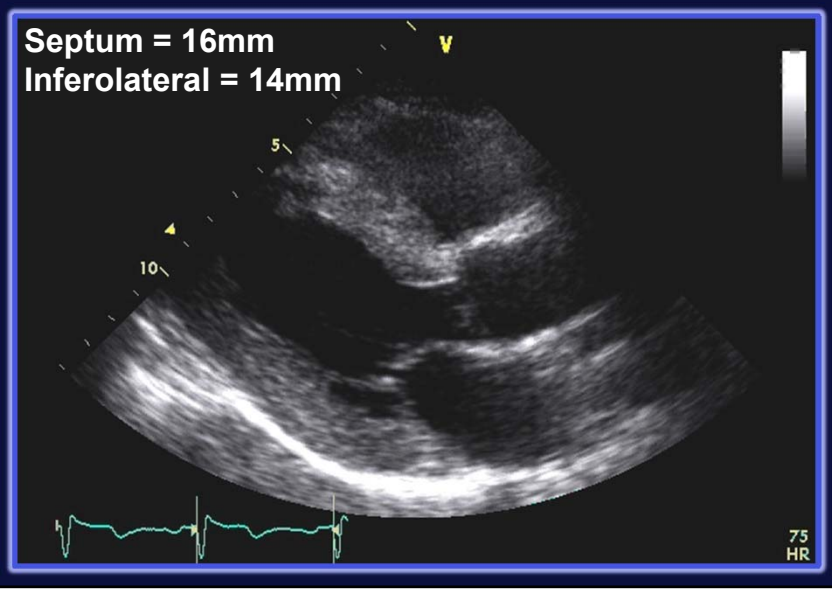
Case

- 42 year old male
- Played football in high school. Continues to exercise and lift weights
- Murmur noted on exam

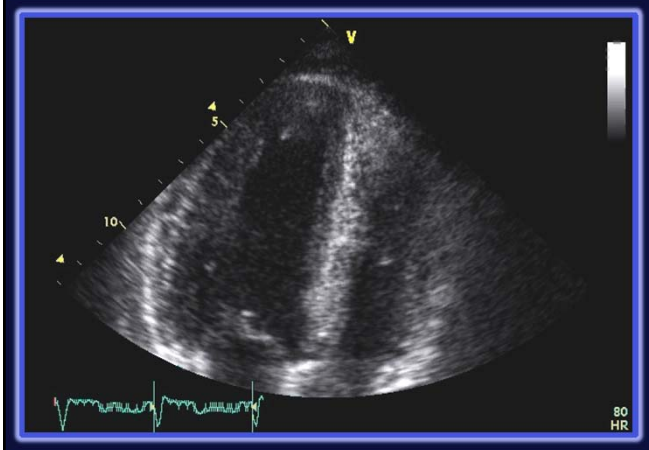
Electrocardiogram



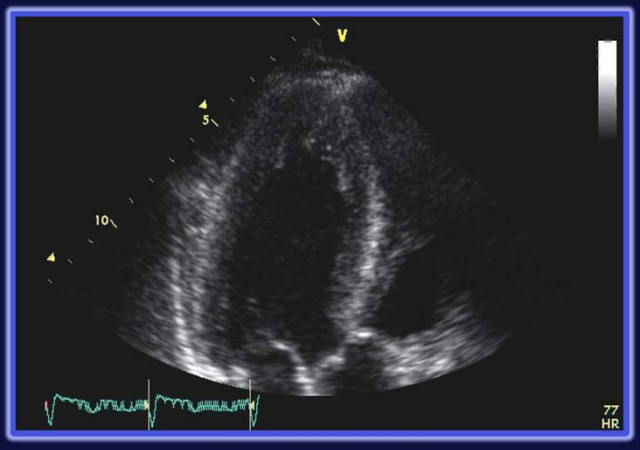
Parasternal Long Axis

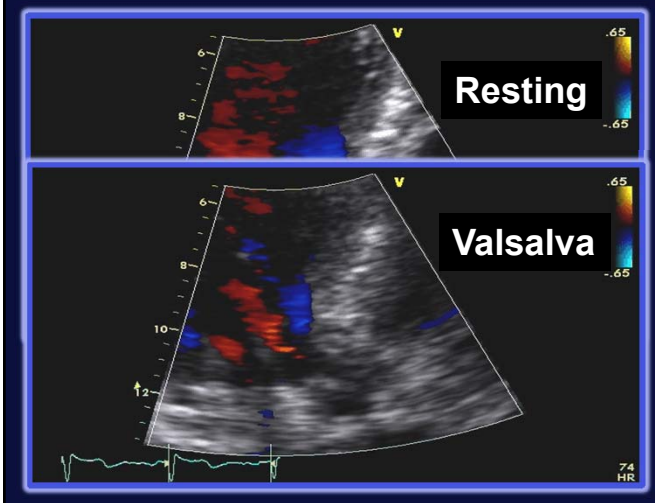


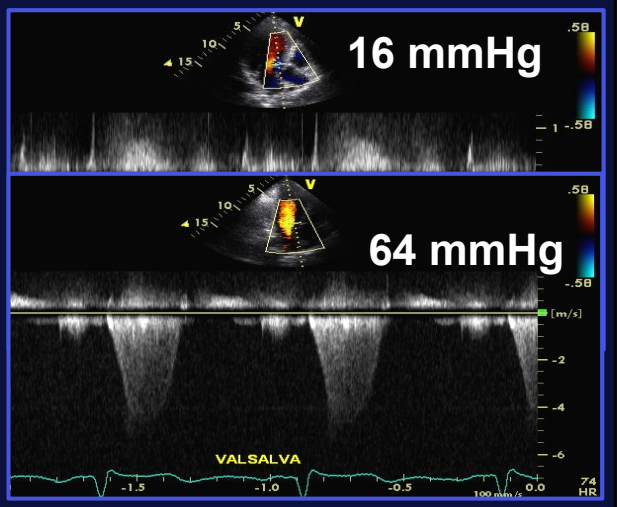
A4C



A3C







Hypertrophic Cardiomyopathy

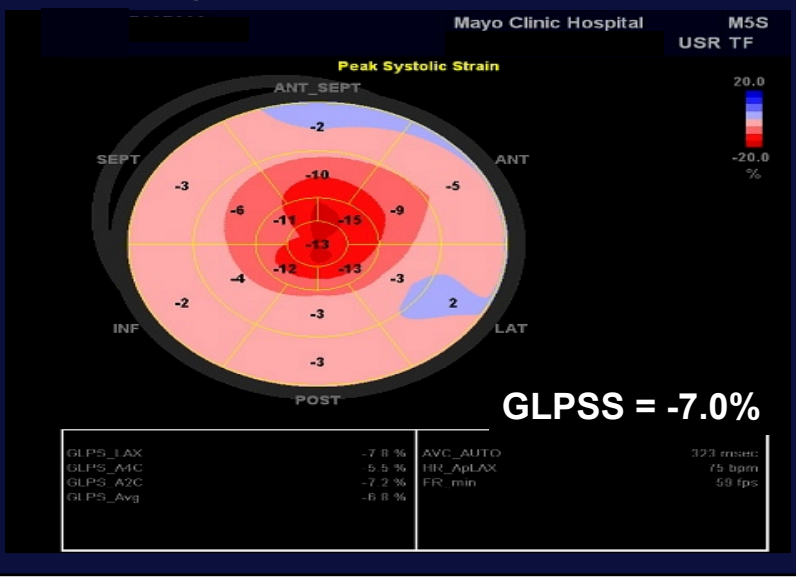
Echocardiographic Diagnosis

Left Ventricular Hypertrophy ≥ 15mm

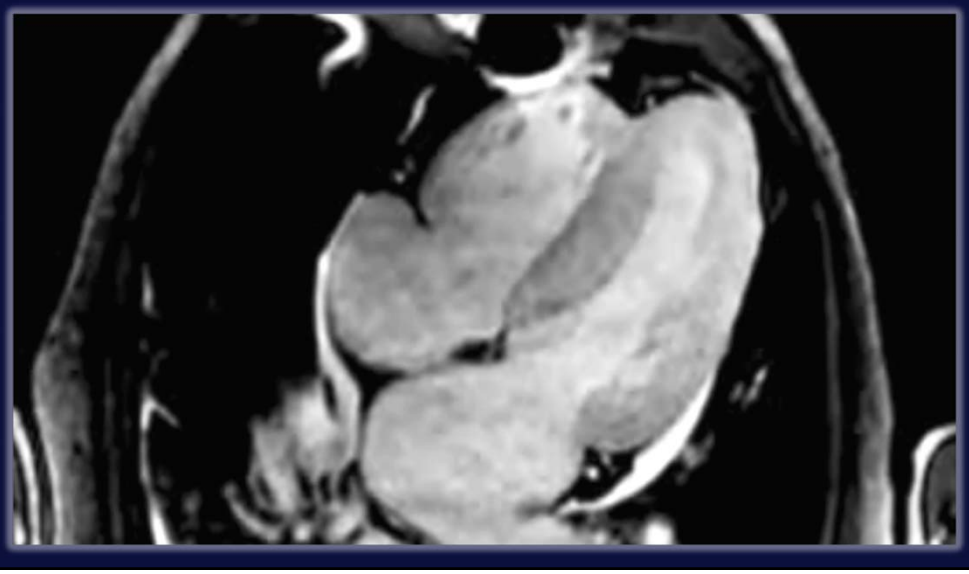
In the absence of another cardiovascular or systemic disease associated with LVH or myocardial wall thickening

Maron et al. J Am Coll Cardiol 2003;42: 1687

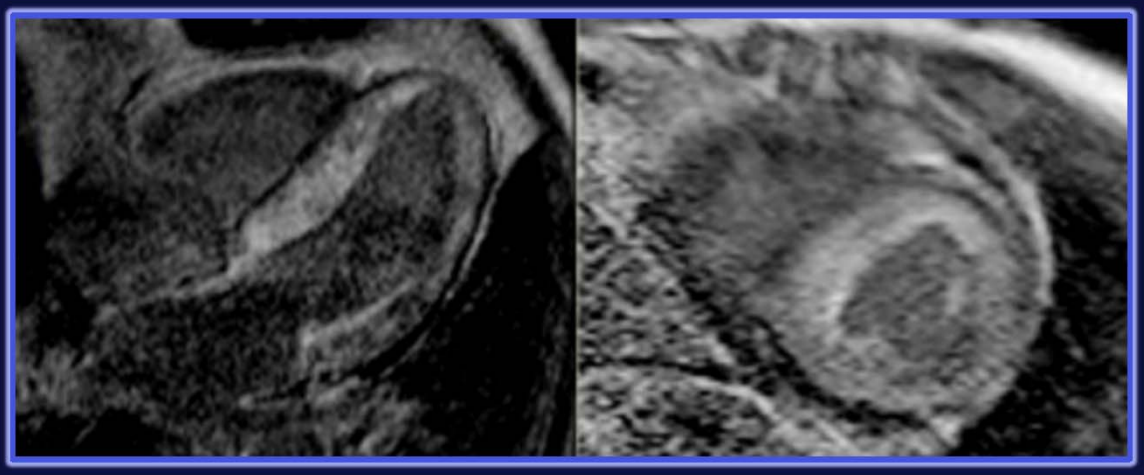
Global Longitudinal Peak Systolic Strain



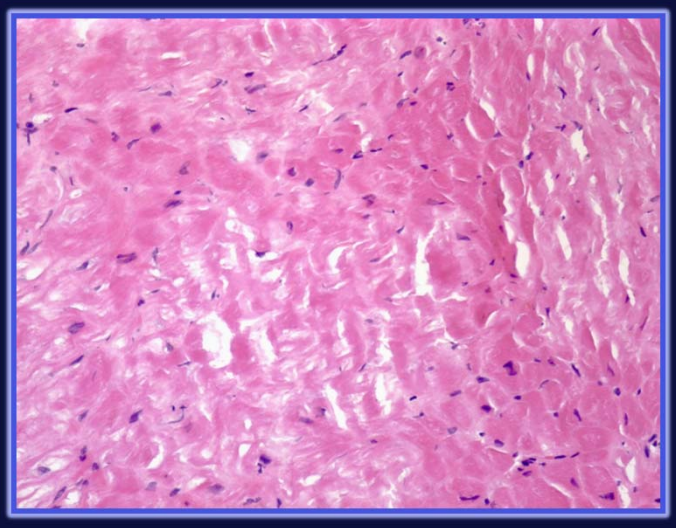
MRI



Late Gadolinium Enhancement

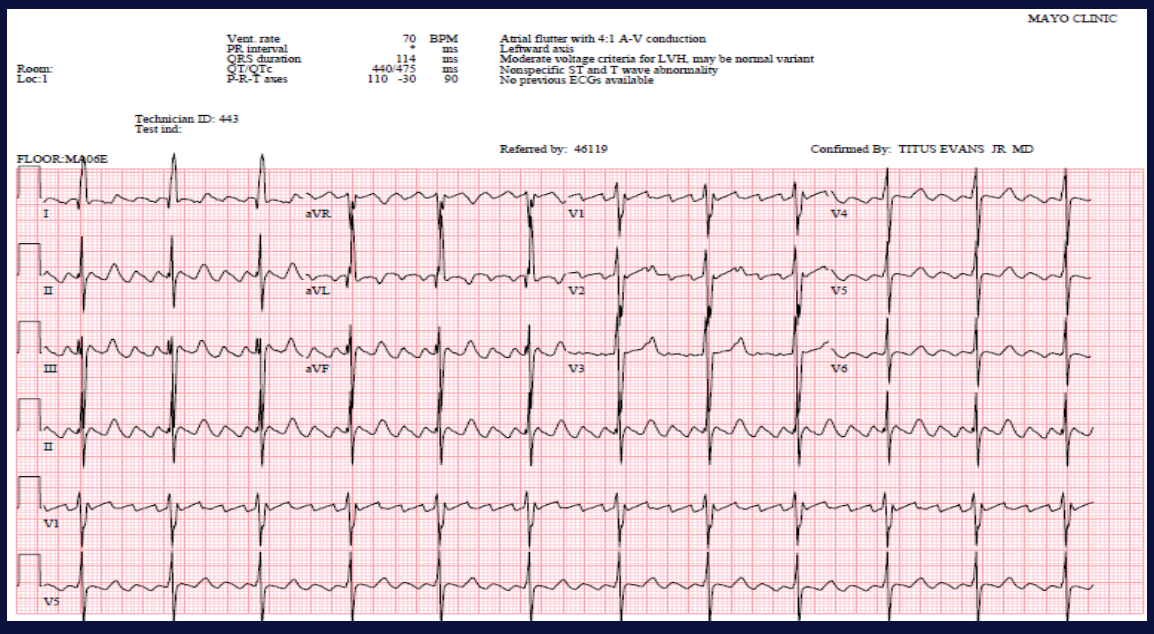


Amyloidosis

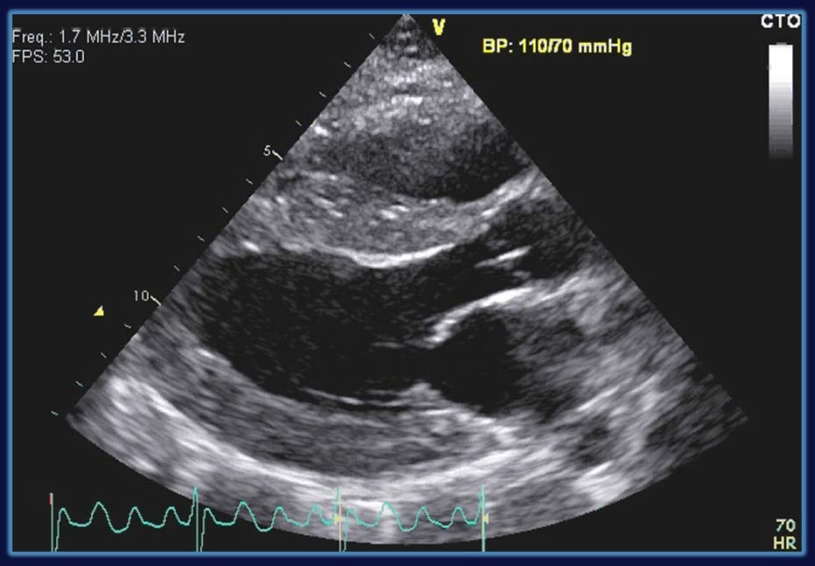


Case

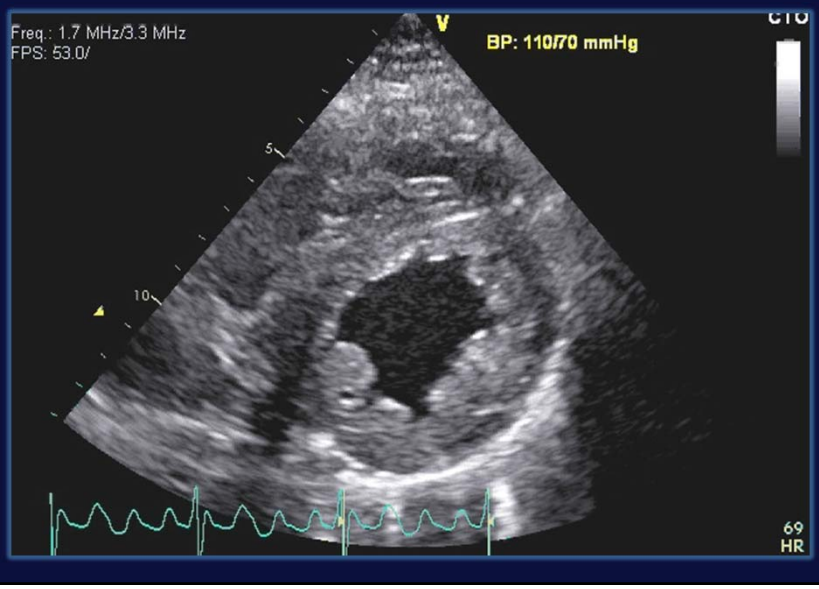
- 19 year old female
- No family history of cardiovascular disease
- NYHA II, shortness of breath and muscle weakness.
- Presents with palpitations



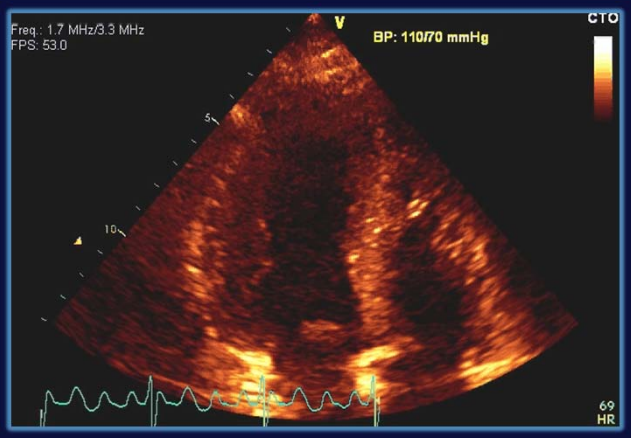
Parasternal Long Axis

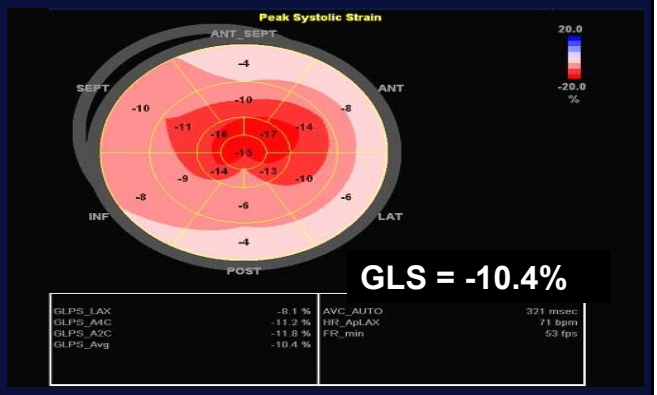


Parasternal Short Axis



Apical 4 Chamber & Global Longitudinal Peak Systolic Strain

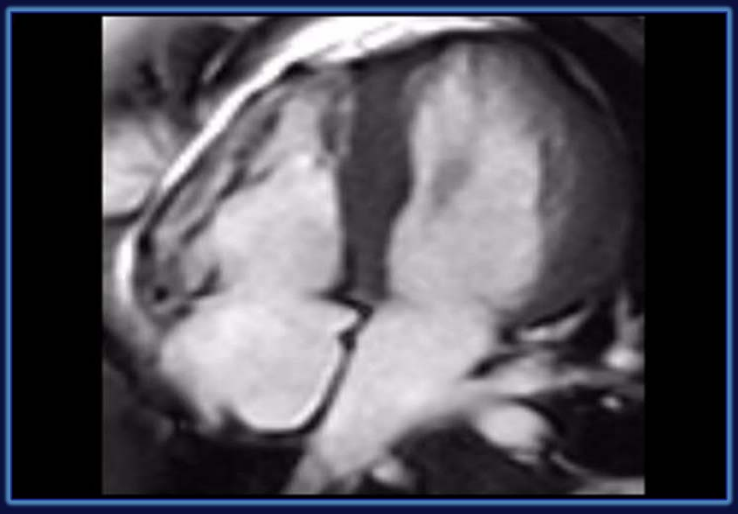




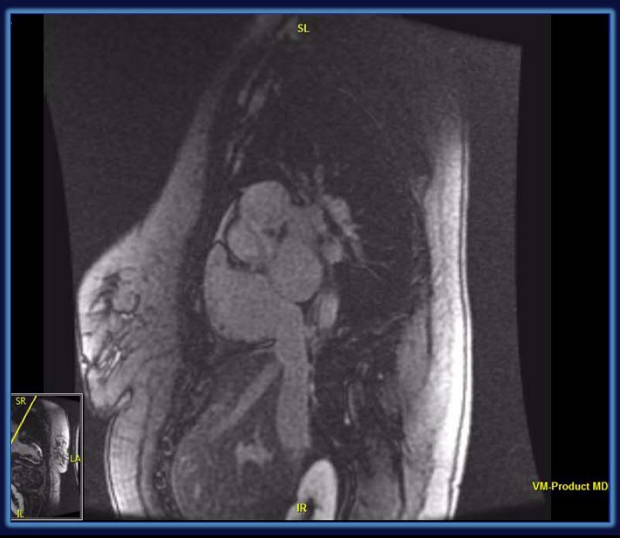
Diagnosis?

1. Hypertrophic Cardiomyopathy
2. Amyloidosis
3. Glycogen Storage Disease
4. More information needed
5. Ask Dr. Lang?

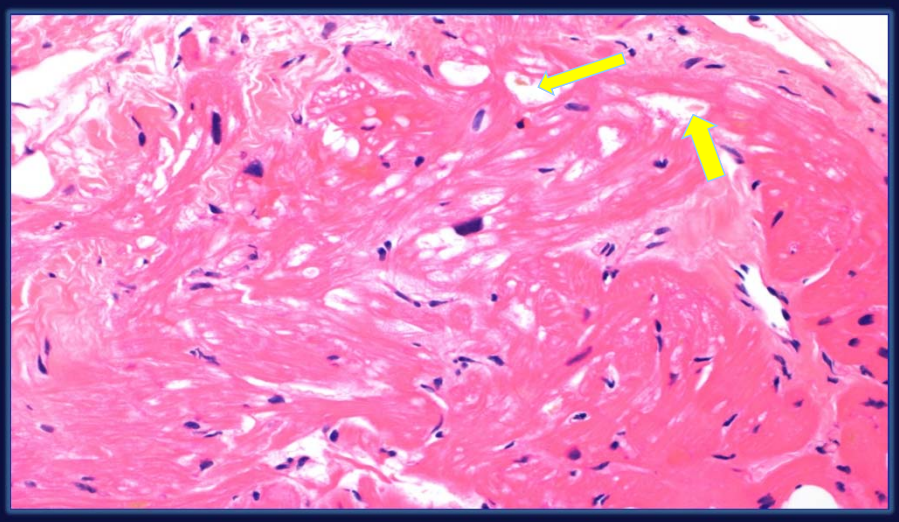
Additional Testing
Cardiac MRI



Additional Testing
Cardiac MRI- LGE



Myocardial Biopsy

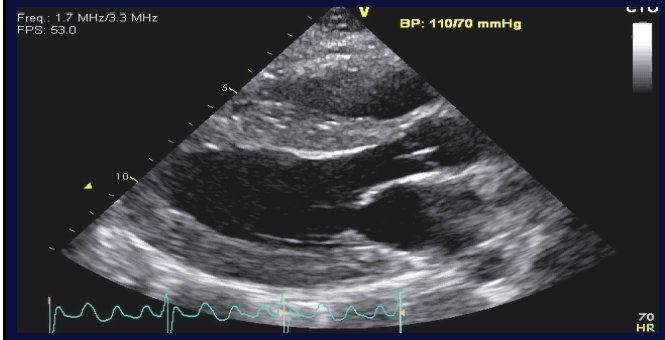


Comprehensive Cardiomyopathy Panel

Disease causing mutation in the LAMP2 gene

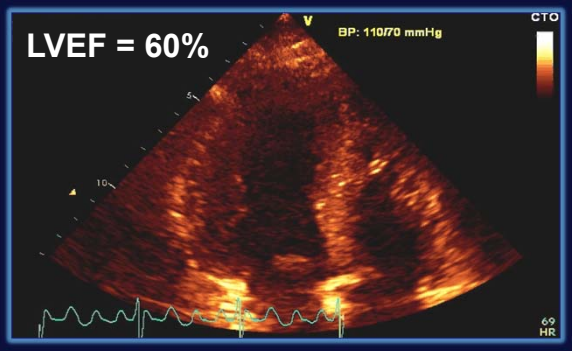
Danon Disease

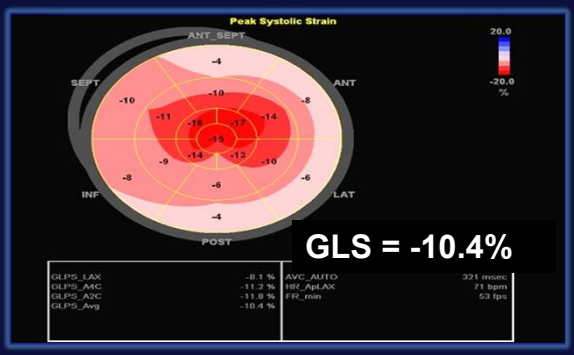
Danon Disease



- Loss of function LAMP2
- X-linked dominant
- Inability to transport cellular material into lysosomes…accumulate autophagic vacuoles in muscles (glycogen storage disease)
- Skeletal myopathy
- Cognitive dysfunction
- Cardiomyopathy (*HCM*, DCM)

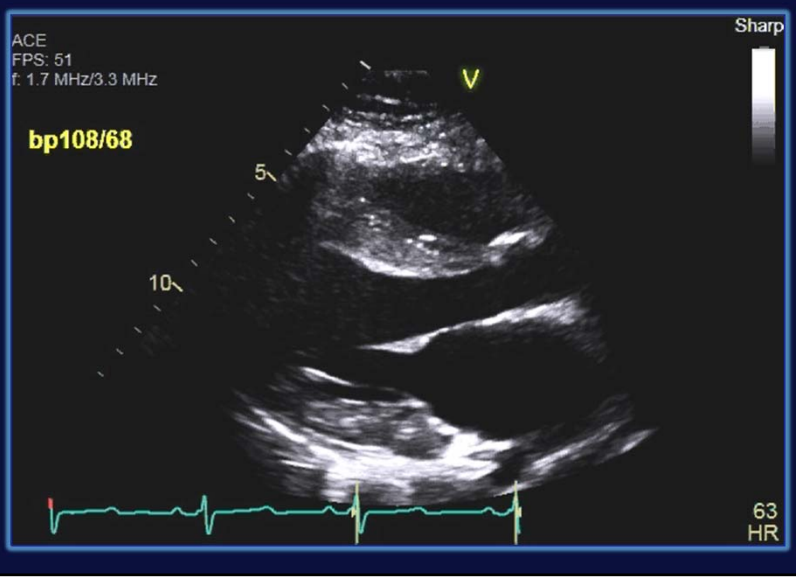
Apical 4 Chamber & Global Longitudinal Peak Systolic Strain





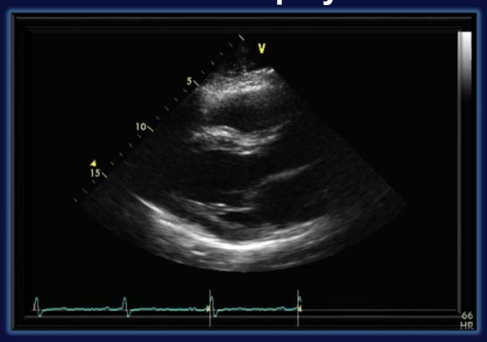
LVEF : GLS ratio 5.8 (> 4.1)
Relative Regional Strain Ratio = 0.74 (< 1!!)

Today at age 23



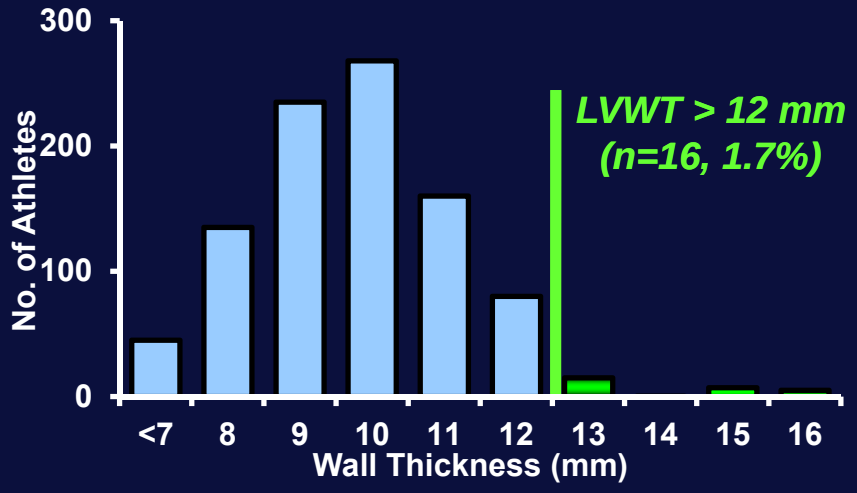
Athlete or HCM ?

30 y/o male professional
Football player



26 y/o male family
history of HCM

Distribution of LVWT in 947 Elite Athletes?



Pelliccia et al N Engl J Med 1991;324:295

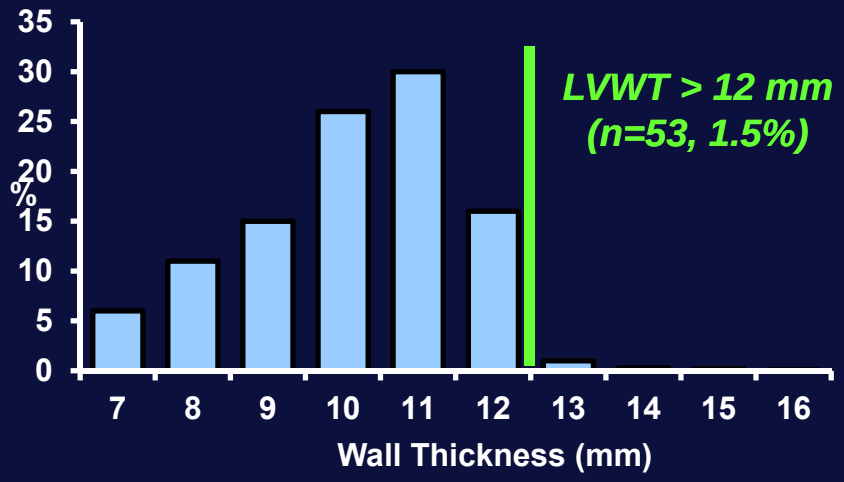
Distribution of LVWT in 947 Elite Athletes?

Of the 16 with LVWT > 12mm

- All had EDD >54mm
- All had normal LA dimension
- All were men, no women >11mm

Pelliccia et al N Engl J Med 1991;324:295

Distribution of LVWT in 3500 Elite Athletes?



Basavarajaiah et al. J Am Coll Cardiol 2008:51:1033

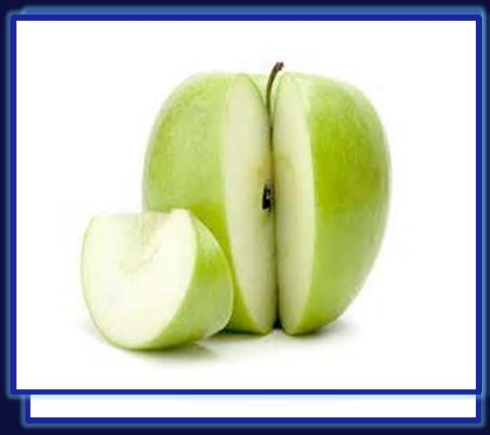
Distribution of LVWT in 3500 Elite Athletes?

Of the 53 with LVWT > 12mm

- 50 had EDD >58mm
- All had normal LA dimension and diastolic function
- All were men

Basavarajaiah et al. J Am Coll Cardiol 2008:51:1033

Are They Really The Same?



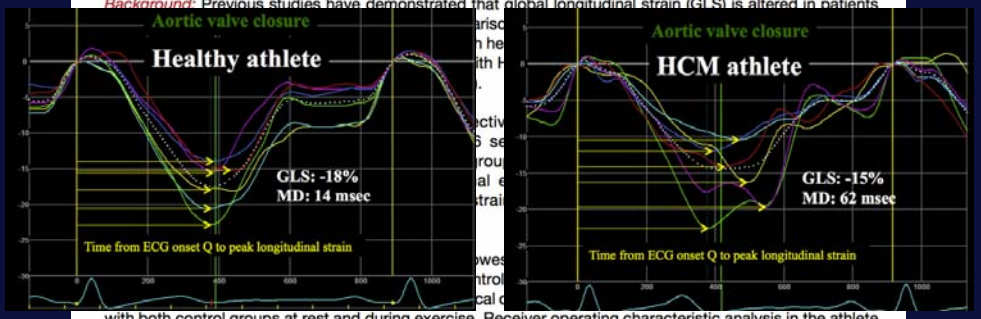
Athletes vs HCM
Gray Zone LVWT

	Criterion	*Sensitivity*	*Specificity*	*AUC*
LVRWT	<0.6	96	86	0.97
Septal e' (cm/sec)	>9	86	70	0.75
Long-endo ε (%)	<-15	79	67	0.72
Long-endo ε / LVRWT	<-30	82	95	0.94

Kansal MM et al. Am J Cardiol 2011;108(9):1322-6

Mechanical Dispersion by Strain Echocardiography: A Novel Tool to Diagnose Hypertrophic Cardiomyopathy in Athletes

Frédéric Schnell, MD, PhD, David Matelot, PhD, Magalie Daudin, MD, Gaelle Kervio, PhD, Philippe Mabo, MD, PhD, François Carré, MD, PhD, and Erwan Donal, MD, PhD, *Rennes, France*



with both control groups at rest and during exercise. Receiver operating characteristic analysis in the athlete groups demonstrated that resting mechanical dispersion (area under the curve = 0.949 ± 0.023) had better ability to identify HCM compared with GLS at rest (area under the curve = 0.644 ± 0.069) ($P < .001$) or during exercise (area under the curve = 0.706 ± 0.066) ($P < .005$).

Conclusions: In athletes, normal resting GLS does not rule out the diagnosis of HCM. Mechanical dispersion of longitudinal strain seems to be a promising tool for the diagnosis of HCM in athletes. (J Am Soc Echocardiogr 2016;■:■-■.)

Athlete's Heart versus HCM

	HCM	Athlete's Heart
LV wall thickness	≥ 15 mm	< 15 mm (usually < 13 mm)
Morphology	Asymmetric	Symmetric
LVEDD	<45mm	>55mm
Diastolic filling	Abnormal	Normal
LA volume	Increased	Normal
Response to deconditioning	None	Regression of LVH
Strain Imaging*	Abnormal	Normal
MRI (LGE)	Present	Absent

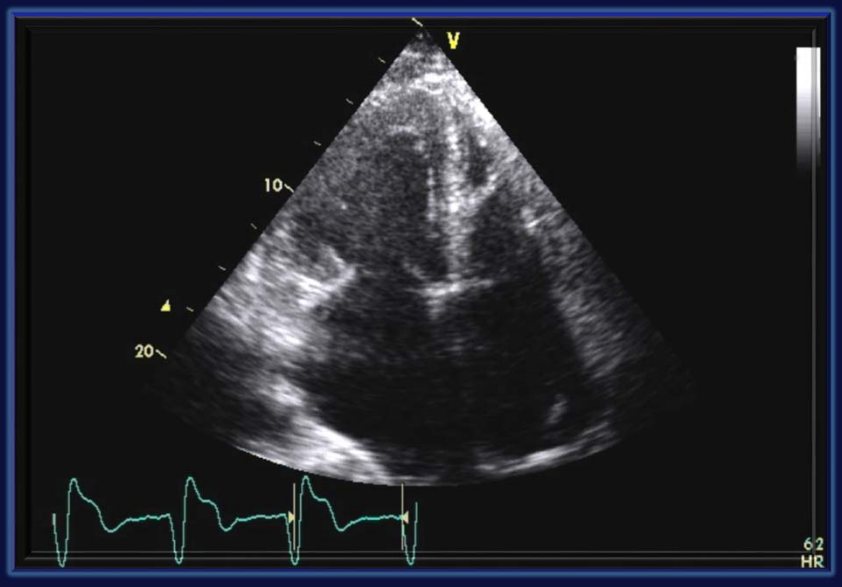
Maron BJ. Heart 2005; 91: 1380

* Butz T, et al. Int J Cardiovasc Imaging 2011; 27:101

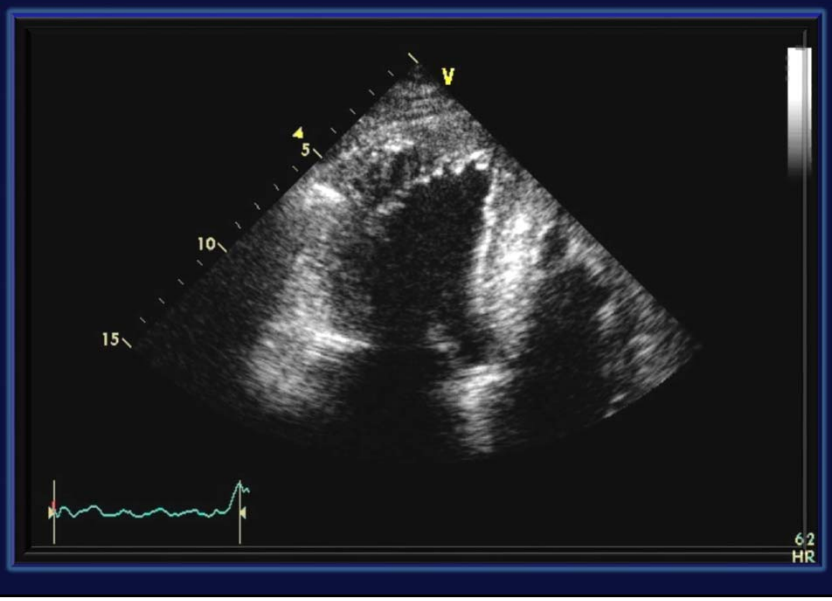
Back to This Case

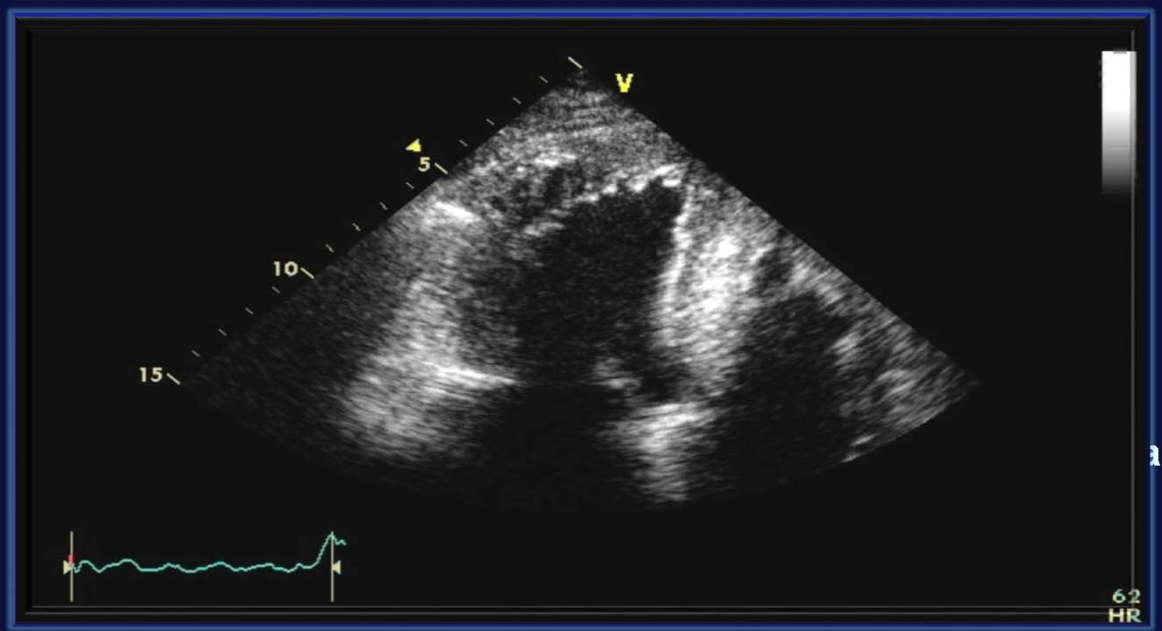
- 47 year old male
- 2005 several near syncope episodes.
- Eventually while at a the Phoenix Suns game had a true syncopal episode.

Echo 2007



Echo 2012





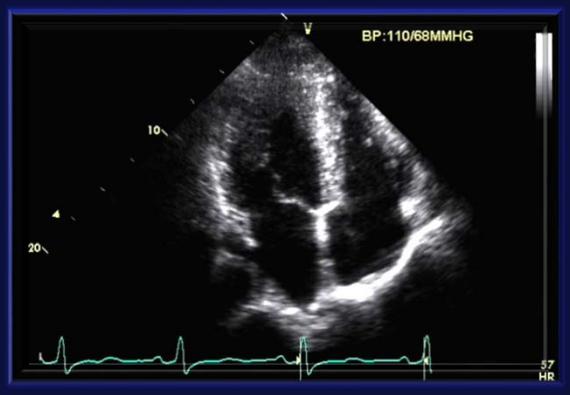
HEART

Apical hypertrophic cardiomyopathy and left ventricular non-compaction: two faces of the same disease

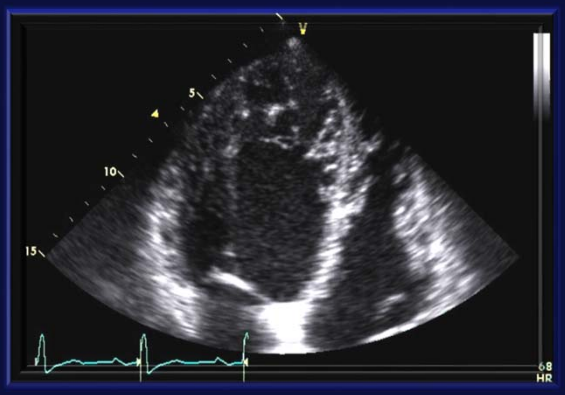
L Monserrat, R Barriales-Villa and M Hermida-Prieto

Heart 2008 94: 1253

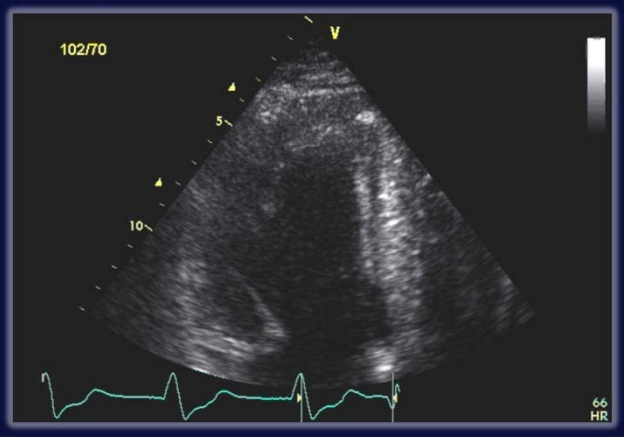
Father

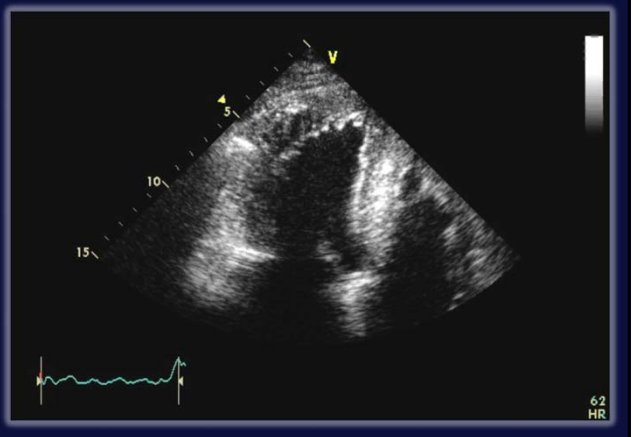


Son



2005-2013



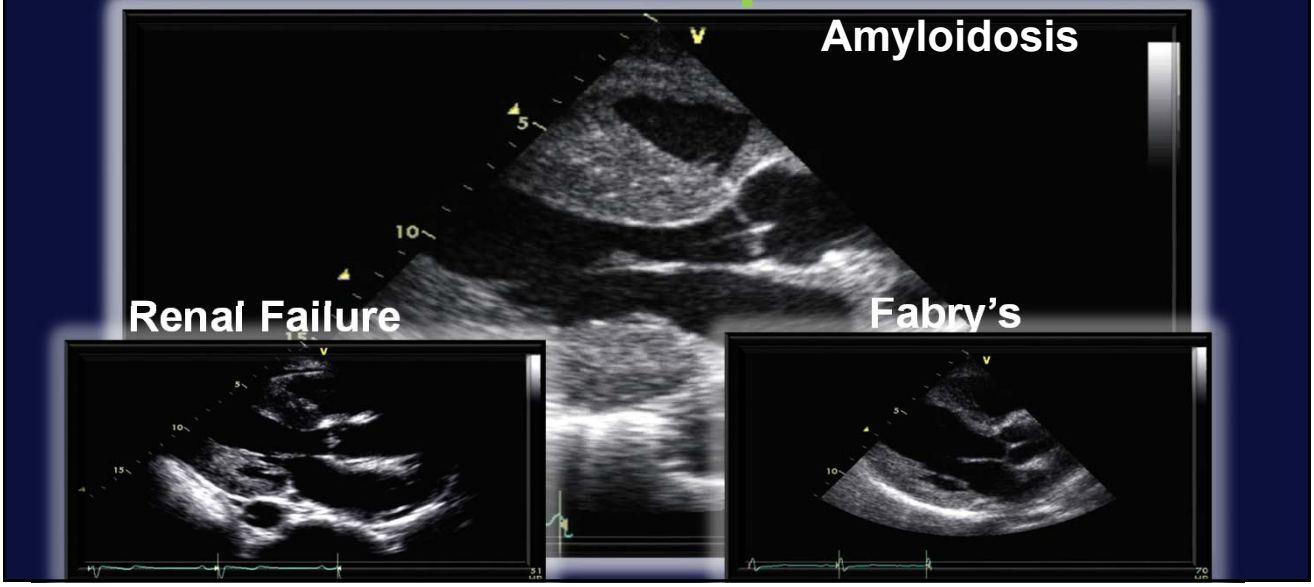


Thick Walls Why?

It's What's on the Inside that Matters

Morphology Not Histology

Phenocopies




MAYO
CLINIC